



Stanislaus County Benefit Enrollment Form 2017 – Early Retiree

Please complete this universal benefit enrollment form in its entirety when enrolling or making changes to your Medical Benefit. Refer to your Benefit Guide for detailed information on your medical plan options. Check the box next to the option of your choice. Enter all dependent information if necessary. If there is a Qualifying Life Event change, submit this completed form and backup documentation within 60 days of the qualifying event. **Marriage and/or Birth Certificates are required when enrolling a new Dependent in a Health Plan.**

1. Main Subscriber's General Information

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Qualifying Life Event Change Type :	Change Date:	ID #: For office use
Last Name:	First Name:	MI	New Last Name: (If applicable)
Address:		City:	State: Zip Code:
Home Phone:	Cell:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Social Security #:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	E-Mail Address:	
Main Subscriber: <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Beneficiary		Are you covered by Medicare Parts A & B? <input type="checkbox"/> Yes <input type="checkbox"/> No If you marked Yes, you are not eligible to enroll in this plan.	

2. Medical Plan Options and Monthly Premiums

Coverage Level	SCPH or Anthem	
	HDHP	EPO
Subscriber Only	<input type="checkbox"/> \$654.31	<input type="checkbox"/> \$782.38
Subscriber +1	<input type="checkbox"/> \$1,308.62	<input type="checkbox"/> \$1,564.74
Subscriber +2 or More	<input type="checkbox"/> \$1,766.68	<input type="checkbox"/> \$2,112.42

3. Dependent Information – Complete all dependent information below. Marriage and/or birth certificates are required for dependents enrolled in a medical plan.

Dependent Name	Social Security #	Relationship	Date of Birth	Sex	Add	Delete
1.					<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>

4. Acceptance and Payment Agreement – Please read the following and acknowledge by signing below.

I understand that I may continue my medical benefits for myself and my covered eligible dependents, upon retirement. In order to qualify, I know that I, and/or my dependents, cannot be covered by another group health plan through another source, including Medicare. I understand that when I, and/or my dependents, turn 65, I, and/or my dependents, will be canceled from this medical plan.

I understand that by signing below, I am acknowledging my enrollment in the medical plan option selected for the plan year indicated on this enrollment form. Should changes take place affecting eligibility of this enrollment, I will immediately inform Stanislaus County Employee Benefits of the change. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I am entitled to a copy of this signed authorization for my files.

Subscriber Signature:	Date:
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5. Recipient of Monthly Retirement Benefit

Retiree Spouse Beneficiary

Last Name:	First Name:	Social Security #:
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I agree to have my monthly medical plan premium of \$ _____ (total of premium from page 1 of this form) deducted from my StanCERA retirement check. I understand that StanCERA will not take partial deductions from my retirement check. If there is not enough money to cover my full medical plan deduction, I agree to pay Stanislaus County directly by check or money order, the total premium owed, by the 1st every month or my coverage may be canceled.

Recipient Signature:	Date:
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