CHIEF EXECUTIVE OFFICE
Human Relations Division
Employee Benefits

1010 10th Street, Suite 1400, Modesto, CA 95354
Phone: 209.525.5717 Fax: 209.525.5779
earlyretirees@stancounty.com

2027 Stanislaus County Early Retiree Benefit Enrollment Form

Please complete this 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 applicable. If there is a Qualifying Life Event change, submit this completed form and backup documentation within **60 days** of the qualifying event. **Certified marriage/Registered Domestic Partner and/or birth certificates along with social security numbers are required when enrolling a new dependent in a health plan. Please note that anyone age 65 or over is not eligible to the Early Retiree medical plan due to Medicare eligibility.**

1. Main Subscriber's General Information

☐ Open Enrollment	Qualifying Life Event Change Type :	Change Date:	ID #: For office use
Last Name:	First Name:	Middle Initial:	New Last Name:
Home Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Gender: ☐ Male ☐ Female	Date of Birth:
Social Security #:	Marital Status: ☐ Married ☐ Single	E-Mail Address:	
Main Subscriber: ☐ Retiree ☐ Spouse ☐ Child Dependent	Are any subscribers covered by Medicare? Yes ☐ No ☐ If you marked Yes, you are **not** eligible to enroll in this plan.		

2. Select Your Medical Coverage

Health Plan of Northern California (HPNC) or UnitedHealthcare (UHC) based on physical home address

Level of Coverage	Subscriber	Subscriber + 1	Family
High Deductible Health Plan (HDHP)	☐ $1,051.62	☐ $2,104.26	☐ $2,840.70
Exclusive Provider Organization (EPO)	☐ $1,256.64	☐ $2,515.32	☐ $3,395.58

3. Dependent Information – Complete all dependent information below
Marriage and/or birth certificates, and social security numbers are required for dependents

Dependent Name	Social Security #	Relationship	Date of Birth	Sex	Add	Delete
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐

4. Acceptance 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 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 understand that the County will continue to establish medical insurance premium rates each year based on actuarial and underwriting recommendations and the County reserves the right to adjust medical insurance premium rates based on these recommendations. I further understand that I am responsible for paying any increase in monthly premium rates made due to these recommendations.

I understand that monthly premium payments are due the 1st of every month and can be paid by check, money order or, if eligible, deduction from my StanCERA retirement benefit. 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 the total premium owed to Stanislaus County Employee Benefits directly by check or money order. If payment is not received by the 1st of the month, my coverage may be canceled.

This authorization will remain in effect until it is revoked in writing by the County, myself or I attain age 65. I will submit any revocations in writing to Stanislaus County Employee Benefits. I am entitled to a copy of this signed authorization for my files.

Subscriber Signature:	Date:

5. Authorization of Deduction by Recipient of Monthly Retirement Benefit

☐ Retiree

Last Name:	First Name:	Social Security #:

By signing this form, I hereby authorize StanCERA to deduct from my retirement benefit the amount requested by Stanislaus County Employee Benefits and pay that amount to Stanislaus County Employee Benefits. I understand that StanCERA deducts members' premiums as a courtesy and that StanCERA has no duty or obligation to verify the accuracy of any information provided by its members or Stanislaus County Employee Benefits. I agree that StanCERA is not responsible for determining the amount that should be deducted to cover the cost of my current premiums. I further agree not to hold StanCERA liable for any discrepancy in premiums deducted from my retirement benefit. If a discrepancy in the amount withheld arises, I will contact Stanislaus County Employee Benefits directly to remedy the issue, and should any additional payment or refund be required, I will handle such transaction with Stanislaus County Employee Benefits directly.

I agree that StanCERA is neither a party nor beneficiary to my agreement with Stanislaus County Employee Benefits and that StanCERA is hereby released from liability for negligence, intentional acts, damages, or any other claims (known or unknown) arising from my agreement with Stanislaus County Employee Benefits.

This authorization will remain in effect until it is revoked in writing by StanCERA, myself or I attain age 65. I will submit any revocations in writing to Stanislaus County Employee Benefits.

Retiree Signature:	Date: