CHIEF EXECUTIVE OFFICE
Human Relations Division
Employee Benefits

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2022 Stanislaus County COBRA Benefit Enrollment Form

Please complete this benefit enrollment form in its entirety when enrolling or making changes to your benefits. Refer to the employee benefits website for detailed information on your benefit 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, you must submit this completed form and backup documentation within **60 days** of the qualifying event. **Certified marriage and/or birth certificates along with social security numbers are required when enrolling a new dependent in a health plan.**

1. Employee General Information

☐ Open Enrollment Change	☐ Qualifying Life Event Change Type	Change Date:	Employee ID:
Last Name:	First Name:	New Last Name: (If applicable)	MI
Home Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Gender: ☐ Male ☐ Female	Date of Birth:
Social Security #	Marital Status: ☐ Single ☐ Married	Home Email:	

2. Medical Plan Options and Monthly Premiums

Health Partners of Northern California and UnitedHealthcare

High Deductible Health Plan (HDHP)		Exclusive Provider Organization (EPO)	
☐ Employee Only	$666.06	☐ Employee Only	$796.62
☐ Employee + 1	$1,333.14	☐ Employee + 1	$1,593.24
☐ Family	$1,799.28	☐ Family	$2,151.18

☐ **Waive Medical Coverage**

3. Dental / Vision Plan Options and Monthly Premiums

Delta Dental (Choose Only One Dental Plan)			Vision Service Plan
Core Dental Plan		**Buy-Up Dental Plan**	
☐ Employee Only	$34.68	☐ Employee Only	$58.14	☐ Employee Only	$7.65
☐ Employee + 1	$69.36	☐ Employee + 1	$115.26	☐ Employee + 1	$15.30
☐ Family	$120.36	☐ Family	$198.90	☐ Family	$20.40
☐ **Waive Dental Coverage**			☐ **Waive Vision Coverage**		

4. Dependent Information for Health Plans

List all dependent information and indicate coverage for medical, dental, and vision. **Marriage and/or birth certificates along with social security numbers are required for dependents enrolled in health plans.**

Last Name, First Name	Social Security Number	Relationship	Date of Birth	Gender	Add	Delete	Medical	Dental	Vision
1.					☐	☐	☐	☐	☐
2.					☐	☐	☐	☐	☐
3.					☐	☐	☐	☐	☐
4.					☐	☐	☐	☐	☐
5.					☐	☐	☐	☐	☐
6.					☐	☐	☐	☐	☐

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

I understand that under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), I may continue medical, dental and vision insurance benefits for myself and my covered eligible dependents, upon termination of my employment with Stanislaus County. 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. Premium payment obligation begins when County sponsored group coverage ends.

If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

I understand that by signing below, I have made an election for my benefits package for the plan year indicated on this enrollment form. Any choices I have made may only be altered as the result of a change in family status. Should changes take place affecting these statements, 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.

Employee personal information is protected under Federal HIPAA Law.

I agree to pay Stanislaus County the total premium owed for my COBRA coverage; 60 days from beneficiary receipt of Notice, or COBRA eligibility for this Qualifying Event; once elected, initial payment due 45 days from election, and, after initial payment, by the 1st of every month or my coverage may be canceled.

Signature:	Date: