Benefit Application & Change Form

County of Imperial

Will Only Be Accepted with Required Documentation

p New Enrollee p Change of Status p Bargaining Unit Change

Employee Information (please type or print clearly. Use black ink.)

Social Security Number	Last Name	First Name	M.I.

Current Mailing Address: (STREET, CITY, STATE, ZIP)

Home Phone	Department	Position Title

Hire Date	Date of Birth	Personal Email Address

Health Coverage Election

p I wish to waive Health, Dental & Vision Coverage.
If you, your spouse or dependent(s) are refusing coverage, please complete and sign the Refusal of Personal Coverage Form.

Section A
Check Qualifying Event

p Marriage
p Newborn
p Loss of Previous Coverage
p Divorce
p Death
p Reached Maximum Age Limit
p Other: _____

Date of Qualifying Event:
_____

Section B
Family Category

p Employee Only
p Employee + Spouse/Domestic Partner*
p Employee + Child(ren)**
p Employee + Family

Section C
Medical Plan Level

p Plan I/500 Deductible
p Plan II/1500 Deductible

p Plan I – Dual p Plan II - Dual
(Only if spouse is a County employee)

Section D
Dental & Vision Plan

p Principal Self – Funded Dental PPO
p Dental Health Services (DHS)- HMO
(Provider #_____)
p Waive Dental Insurance

p Vision Service Plan (VSP)
p Waive Vision Insurance

Spouse & Dependent Information (Proof of Dependent Eligibility required at submittal time)

Section E

Is your Spouse also a County employee? p YES p NO

Do you currently have Health Coverage with the County as a dependent? p YES p NO

Spouse/Reg. Domestic Partner Last Name	First Name	Gender	Date of Birth	Social Security #	
					p Add p Delete
Child's Last Name	Child's First Name	Gender	Date of Birth	Social Security #	
					p Add p Delete
Child's Last Name	Child's First Name	Gender	Date of Birth	Social Security #	
					p Add p Delete
Child's Last Name	Child's First Name	Gender	Date of Birth	Social Security #	
					p Add p Delete

*Legally married or registered domestic partner in the state of California.
**Natural born children, stepchildren and/or those awarded by court order up to age 26.
***Medical Coverage required to purchase Dental or Vision benefits and must be at same Family Category (waiver form must be completed).

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Medical & Dependent Flex 125

You can contribute up to $3,300 per calendar year to your Health Care Reimbursement Account and/or $5,000 per calendar year to your Dependent Care Reimbursement Account. Please refer to IRS for further limitation restrictions.

Health Care	Dependent Care
Reimbursement Account: $ _____ Annual	Reimbursement Account: $ _____ Annual

IRS requires that reimbursement accounts be used in full each year. Unused portions will be forfeited (lost).
In order to participate it must be renewed every year. County reserves the right to collect any contributions pending at time of separation.

*** HR USE ONLY**

Bi - Weekly $_____ Number of Pay Periods Remaining_____

Basic Life Insurance Beneficiaries

This designation of beneficiaries applies to your basic life insurance available through County of Imperial.
Employee Coverage Amount
Employee Basic Life Coverage: $100,000 Management & Public Safety Management: $125,000 Department Heads Basic Life Coverage: $150,000

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Authorization:

I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which my coverage may be issued under the plan. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I further authorize County of Imperial to deduct from my earnings the contribution (if any) required toward the cost of this plan. I understand that I must submit the necessary documents to verify all dependents that I add to the plan are eligible and remove any dependents from the plan when they are no longer eligible for coverage.
I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of CA.

Authorization for Disclosure of Personal Information: by signing below, you authorize any "provider of care", insurer, plan or your Blue Shield of California agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & health Insurance Company (individually or collectively referred to as Blue Shield), or its representatives,and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield of California to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from and institutional source or insurance support organization that gathers this type of information, for the purpose of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and understand that you are entitled to a copy of this form and that a photocopy is as valid as the original.

The above selection can only be changed within 31 calendar days of a Qualifying Event, with written request and proof or until Open Enrollment.

_____

Qualifying Event Includes: marriage, newborn, divorce, loss of previous coverage, Medicare entitlement, adoption; etc.
I, the applicant, acknowledge that I have read and understood this Application in its entirety.

Signature Date

Official Use Only

Effective Date:_____ Employee #: _____ Bargaining Unit: _____ p New Hire p Re-Hire

Primary Dual p Secondary Dual p with Employee #: _____ Name: _____

Employee Is: Management p Non – Management p

Dental/Vision Gifted: Yes p No p

Default: p Yes p No (Application received after 31 days of date of hire)

Received: