



**ACTIVE EMPLOYEE
HEALTH PLAN ELECTION/CHANGE FORM**

EMPLOYEE BENEFITS OFFICE

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Office Use Only

Effective Date _____
Group Number _____ Certs _____
Rate Change Yes No Date _____
Rep Unit _____ Verified _____

Kaiser Permanente <input type="checkbox"/> HMO <input type="checkbox"/> HDHP HMO	Health Net <input type="checkbox"/> HMO	Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> HDHP PPO	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Dependent(s)	Waive <input type="checkbox"/>	<input type="checkbox"/> Tier A <input type="checkbox"/> Tier B*	HSA Annual Election (Form Required) \$ _____
<input type="checkbox"/> New Hire <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change Tier <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name <input type="checkbox"/> Return LOA/Break in coverage From _____ To _____ Event _____ Date of Event _____					<input type="checkbox"/> County <input type="checkbox"/> Special District Hire Date _____ Are you actively working? <input type="checkbox"/> Yes <input type="checkbox"/> No	

I. EMPLOYEE

Last Name	First Name	M.I.	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Address			City	State	Zip
Physician Name	Medical Group	PCP/Kaiser Number		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Phone

II. SPOUSE (IRS Dependent? Yes No) DOMESTIC PARTNER (IRS Dependent? Yes No)

Last Name	First Name	M.I.	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Physician Name	Medical Group	PCP/Kaiser Number		Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Group Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

III. DEPENDENT CHILDREN

Last Name	First Name	MI	Date of Birth	Social Security Number	Sex	Physician's Name	Medical Group	PCP/Kaiser #	IRS Dependent	Student	Disabled
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Name and Address of Dependent if Different:

IV. OTHER GROUP COVERAGE INFORMATION

Insured Name	Insured SSN	Carrier Name	Group Number	Coverage applies to: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child(ren)
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V. DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required premiums.

***VI. TIER B:** I understand this election is irrevocable and forfeits all entitlements to cashback and PSI. _____(initial)

VII. I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. My signature indicates my acceptance of the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, benefit coverage, and all associated policies and procedures. (You are entitled to a copy of this signed authorization for your files.)

Employee Signature: _____	Date: _____
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