County of Mendocino
Health Benefits Enrollment Form

To be completed by Human Resources
Employee # _____
Org / Budget # _____
Bargaining Unit _____

Please complete all information below and sign and date this form.

Employee Information

_____
Last Name of Employee, First Middle Initial

_____
Street Address

_____
City State Zip
Phone Number ( ) _____
____/____/____ ____/____/____ _____
Birth Date Hire Date Department

_____/_____/_____ _____
Social Security # Marital Status

Plan Changes (Plan 1 or Plan 2) / Additions / Deletions

Circle One. CHANGE ADDITION DELETION

If you are making a change, please provide the following:

Name of person(s) being added / deleted _____

_____

_____

Qualifying Event _____

Event Date: _____/_____/_____

Dependent Information

Family members not listed will be deleted.

_____	_____	___	____/____/____	____/____/____	
Dependent Last Name, First	Relationship	Sex	Birth Date	Social Security #	
_____	_____	___	____/____/____	____/____/____	
Dependent Last Name, First	Relationship	Sex	Birth Date	Social Security #	
_____	_____	___	____/____/____	____/____/____	
Dependent Last Name, First	Relationship	Sex	Birth Date	Social Security #	

Health Plan

Circle one of the following plans.

Plan I **Plan II**

Circle the family category to indicate who you want to include for coverage:

Employee Only	**Employee Spouse & Child**
Employee & Spouse	**Employee & Child**
Employee & Dom Partner	**Employee, Child & Dom Partner**

Coordination of Benefits

Do you and/or any of your enrolled dependents have medical, dental, vision, or Medicare coverage under any other plan?

Yes _____ No _____. If yes complete below:

_____
Type(s) of coverage

_____
Name(s) of subscriber

_____ _____
Medicare number Carrier(s)

Life Insurance Designation

Only one Beneficiary is required.

_____	_____	_____	_____	_____	
Last Name, First Middle In.	Relationship	Address	Phone		
_____	_____	_____	_____		
Last Name, First Middle In.	Relationship	Address	Phone		

_____ **I do not wish to make any Health Plan Changes at this time.**

_____ **I have other Health Coverage and choose not to participate in the Health Plan at this time. I acknowledge that I have submitted an Opt Out form along with proof of my other insurance coverage to Human Resources.**

I wish to enroll in the above named plan. I acknowledge that the above named spouse/domestic partner is my legally married spouse or registered domestic partner, and the child(ren) are under age 26. My dependents all reside in the U.S. I authorize appropriate payroll deductions be made to cover me and the family members I enroll in the plans. I also authorize the plan administrators, agents and insurers to release medical and other information as necessary for proper administration of benefits under the plans. I understand I cannot change the coverage I have elected until the next open enrollment period unless I have a qualified family status change.

_____ _____/_____/_____
Signature Date

Effective Date: _____

Determined by HR Staff: _____

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