City of Ceres – Medical, Dental, Vision Enrollment Form

Applicant Information:

☐ New Enrollment ☐ Open Enrollment Changes ☐ Waive Coverage | **Effective Date** / /

☐ Qualified Event: ______________________ ☐ COBRA Coverage – Reason: ______________________ ☐ Length of time: __________

Open Enrollment Changes for: ☐ **Medical** ☐ **Dental** ☐ **Vision**

☐ *Add Dependent* ☐ *Delete Dependent* ☐ *Address Change* ☐ *Name Change: Former Name* ______________

Name		**Date of Hire**	/ /
Address		**Social Security #**	
City, State, Zip		**Home Phone**	
Job Title		**Department**	☐ Single ☐ Widowed ☐ Married ☐ Divorced

Email Address

Family Members to be Covered:

(Important: If declining coverage for any dependent(s), complete and sign the "Refusal of Coverage" section on the back of this form.)

☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	**Self**	☐ M ☐ F
☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL 10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	☐ Spouse ☐ Domestic Partner	☐ M ☐ F
☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL 10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	☐ Son ☐ Daughter ☐ Step Child	☐ M ☐ F
☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL 10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	☐ Son ☐ Daughter ☐ Step Child	☐ M ☐ F
☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL 10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	☐ Son ☐ Daughter ☐ Step Child	☐ M ☐ F
☐ Add ☐ Term	☐Sutter LG 20 ☐Sutter LG 18 ☐Sutter HL10 ☐ KP Premium ☐ KP Basic ☐ Dental ☐ Vision	**Last Name** **Social Security #**	**First Name** **Birth Date** / /	☐ Son ☐ Daughter ☐ Step Child	☐ M ☐ F

WAIVER OF COVERAGE

Name		Social Security Number	

Declining MEDICAL Coverage:	Declining DENTAL AND/OR VISION Coverage:
☐ **Medical**	☐ **Dental** ☐ **Vision**
☐ **I decline coverage for myself, my spouse, and all dependents**	☐ **I decline coverage for myself, my spouse, and all Dependents**
☐ **I am covered by another employer's plan (e.g., through your spouse or parent)** Carrier Name and ID Number _____ ***IF COVERED BY ANOTHER EMPLOYER'S PLAN, THE ATTESTATION IS <u>REQUIRED</u> (See below).**	☐ **I decline coverage for my:** ☐ **Spouse Only** ☐ **Children Only** ☐ **Spouse & Children** ☐ **Following Dependents Only:** _____ _____ _____

<u>EMPLOYEE WAIVER OF MEDICAL COVERAGE ATTESTATION</u>

I am aware that I must enroll in an available City medical plan unless I can rightfully opt out. I attest that I can rightfully opt out because:

a. I can provide proof that I have or will have minimum essential coverage thought another source (other than coverage in the individual market, whether or not obtained through Covered California) for myself and all individuals in my tax family (all individuals for whom I intend to claim a personal exemption deduction) for the taxable year or years that begin or end in or with the City's plan year to which the opt out applies ("opt-out period"); and

b. I and my tax family have or will have such minimum essential coverage for the opt-out period.

I understand that I am required to provide this proof/attestation each year that I waive coverage and no later than the end of the City's open-enrollment period.

I understand that failure to provide this proof/attestation as required shall result in **no medical coverage and disqualification from the City's opt-out payment.**

Employee Signature: _____**Date:** _____

_____ (Initial) - If I acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents, may request enrollment in my employer's plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

_____ (Initial) - If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer benefit plan, I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's plan until my employer's next open enrollment period.