



**GROUP ENROLLMENT/CHANGE FORM**

P.O. BOX 45018, FRESNO, CA 93718-5018

(800) 442-7247 FAX (559) 499-2464

- New Enrollment
- Name/Address Change
- Reinstatement
- Rehire

- Annual Enrollment
- Change Enrollment
- Decline Coverage
- Termination

PART 1 EMPLOYEE INFORMATION																	
EMPLOYER <b>CITY OF ST. HELENA</b>				GROUP NUMBER <b>R01</b>		FOR EMPLOYER USE ONLY Loc. Code: StHelen      Department Code:				FOR EMPLOYER USE ONLY Effective Date:							
EMPLOYEE NAME (Last, First, MI)						SS#						<input type="checkbox"/> Medical		<input type="checkbox"/> Dental		<input type="checkbox"/> Vision	
MAILING ADDRESS (Street, City, State, Zip)						HOME PHONE (    )				BIRTHDATE:		MO		DAY		YEAR	
HIRE DATE		ANNUAL SALARY		Full Time/Part Time (Circle one) # of Hours Worked/Week : _____				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED		<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED		<input type="checkbox"/> DOMESTIC PARTNERSHIP <input type="checkbox"/> WIDOWED			
EMPLOYEE TERMINATION DATE			REASON FOR TERMINATION			MEDICAL PLAN SELECTION POA ONLY <input type="checkbox"/> EPO 500				<input type="checkbox"/> EPO 250		<input type="checkbox"/> BlueCard 250 (Out of state Retiree only) <input type="checkbox"/> St. Helena Kaiser					

PART 2 DEPENDENT INFORMATION ONLY											
DEPENDENT INFORMATION (List persons to be covered/terminated.): <sup>1</sup> Relationship Code (relationship to participant) SPO=Spouse DP=DOMESTIC PARTNER CHI=Child											
Add/Drop (Circle)	Last Name	First Name	MI	Social Security ** Required **	Birth Date	Gender (Circle)	Relationship Code(1)	Disabled (Circle)	Plan Selection		
A D						M F	Spouse/DP	Y N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
A D						M F	Child	Y N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
A D						M F	Child	Y N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
A D						M F	Child	Y N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
IF ADDING OR DROPPING DEPENDENT, STATE REASON:											

PART 3 OTHER INSURANCE INFORMATION																
ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached.																
Name of other policy holder		Birth Date		Social Security Number		<sup>2</sup> Rel. Code	Sponsoring Employer			Insurance Carrier or Medicare		Group Number	<sup>3</sup> Benefit Types	<sup>4</sup> Policy Types	Coverage Date(s)	
														Begin / / End / /		
PERSONS COVERED UNDER ABOVE POLICY:																
<sup>2</sup> Relationship Code (specify relation to participant): SPO=Spouse OTH=Other						<sup>3</sup> Benefit Type(s): M=Medical D=Dental V=Vision			<sup>4</sup> Policy Type(s): IND=Individual Policy GRP=Group Plan HMO=Health Maintenance Organization MED=Medicare							

PART 4 COVERAGE DECLINATION											
To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;											
MEMBER DECLINING COVERAGE				COVERAGE DECLINED				REASON FOR DECLINING COVERAGE			
Myself				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/> Covered by spouse's employer group plan			
My Spouse/Domestic Partner				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/> Covered by Medicare			
My Child(ren): _____				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				<input type="checkbox"/> Other: _____			
I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.											
If declining coverage for employee/dependent(s) please sign here. _____ Date _____											

PART 5 DECLARATION											
I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.											
_____ Employee Signature										_____ Date	