County of Sonoma *Extra Help Employees* Medical Benefits Enrollment/Change Form-Confidential Information –Please Print Clearly
All employees must complete all sections of the form. Please follow the instructions included with this form. Employee ID #: _____

Section 1a: Reason for Enrollment/Change	Section 1b: Add/Drop Dependent Coverage	Section 1c: Coverage Level
Mark all boxes that apply: ❑ Annual Enrollment ❑ Newly Eligible Employee ❑ Loss of Other Group Coverage (Date: _____) ❑ Reenrollment ❑ Reinstatement (Date: _____) ❑ Cancel coverage ❑ Lapse coverage during qualifying EH leave of absence ❑ Name Change (Previous Name):_____ _____ ❑ Address Change	**Mark all boxes that apply:** ❑ **Newly Acquired/Eligible Dependent(s) due to:** ❑ Marriage (Date:_____) ❑ Domestic Partnership (Date:_____) ❑ Birth/Adoption/Legal Guardianship (Date: _____) ❑ Loss of Other Group Coverage or Covered CA Date:_____) ❑ Other Reason:_____ (Date:_____) ❑ **Dropping Dependent(s) due to:** ❑ Divorce/Termination of Domestic Partnership (Date: _____) ❑ Over-age Dependent (Date: :_____) ❑ Other Reason:_____ (Date:_____)	**Select Your Coverage Level:** ❑ Self ❑ Self + 1 ❑ Family **County Internal Use Only** **Extra Help Kaiser Permanente Medical Plan** Hire Date: _____ Effective Date: _____

Section 2: Employee's Personal Information

Employee Last Name	**First Name**	**MI**	**Social Security Number**
Street Address	**City, State, Zip Code**		**Date of Birth (MM-DD-YYYY)**
Phone Number	**4-Digit Dept. #**		

Marital Status: ❑ Married ❑ Single ❑ Widow/Widower ❑ Divorced ❑ Domestic Partner

Gender (Employee): ❑ Male ❑ Female

Is your spouse/domestic partner/dependent(s) an employee of the County of Sonoma?
❑ **Yes** ❑ **No** **If yes, list name(s):** _____

Is your spouse/domestic partner a retired employee of the County of Sonoma?
❑ **Yes** ❑ **No** **If yes, list name(s):** _____

Section 3: Medical Plan Choice *(Check all that apply; complete Section 6 if enrolling eligible dependents.)*

- ❑ **ANNUAL ENROLLMENT CHOICE ONLY-**I am electing to **CHANGE MY MEDICAL PLAN ELECTION.**
- ❑ I am a **NEW HIRE/NEWLY ELIGIBLE** employee making my medical plan election.
- ❑ I am electing to **ADD** medical coverage for my **eligible dependent(s).**
- ❑ I am electing to **LAPSE** medical coverage **(Date: _____)**
- ❑ I am requesting to **REENROLL** in medical coverage **(Date:_____)**
- ❑ I am electing to **CONTINUE** current enrollment in medical coverage for **myself.**
- ❑ I am electing to **CONTINUE** current enrollment in medical coverage for my **eligible dependent(s).**
- ❑ I am electing to **DROP** medical coverage for **myself.**
- ❑ I am electing to **DROP** medical coverage for my **dependent(s).** Use **drop** for deleting coverage for your **dependent(s)**.
- ❑ I am electing to **WAIVE** medical coverage for **myself due to enrollment in other group coverage or coverage through Covered CA.** If **waiving** medical coverage you must also complete the *Waiver of Medical Insurance Acknowledgment* (Section 6 of this form).
- ❑ I am electing to **WAIVE** medical coverage for my **eligible dependent(s) due to enrollment in other group coverage or coverage through Covered CA.** If **waiving** medical coverage for your eligible dependent(s), you must also complete the *Employee and Dependent Information* (section 4 of this form) and the *Waiver of Medical Insurance Acknowledgment* (Section 6 of this form). **To waive medical coverage, the dependent (s) must be enrolled in other group coverage or Covered CA.**

Select your medical plan and coverage level.

Select Your Medical Plan	**Select Your Coverage Level**
❑ Kaiser Permanente HMO (602484-0005) ❑ Kaiser Permanente Hospital Services DHMO (602484-0008) ❑ Kaiser Permanente Deductible First DHMO (602484-00011)	❑ 1 – Self ❑ 2 – Self and 1 Dependent ❑ 3 – Self and 2 or More Dependents

Section 4: Employee and Dependent Information

Complete the information below for yourself and all your eligible dependent(s) to be covered or waived on the medical plan. Over-age dependents must meet the eligibility requirement for permanently disabled over-age dependent(s). Refer to the plans' evidence of coverage for more information.

A=Add coverage, D=Drop coverage, C=Continue enrollment in coverage, W=Waive coverage, N/E=Not eligible

Name (First, MI, Last)	Relationship	Social Security Number	Date of Birth (MM-DD-YY)	Gender (M/F)	Enroll in Medical Coverage? (Enter A, D, C, W, or N/E)	Covered by Other Group Coverage? Y/N	Permanently Disabled Dependent? (Y/N, N/A)	Tax Purposes Only Place a ✓ below to indicate dependent status	
								IRS Qualified	Non-IRS Qualified
	self							N/A	N/A

Section 5: Kaiser Permanente Benefit Plan Agreement *(If electing Kaiser, complete the agreement below.)*

Kaiser Permanente HMO, Hospital Services DHMO and Deductible First DHMO Plan

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

_____ _____

Signature Required for Kaiser Permanente Plan ***Date***

Section 6: Employee Authorization, Waiver of Medical Plan Acknowledgement, and Signature

For all enrolled individuals, if any, I agree to comply with the terms of the benefits group contract in which I am enrolled. I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent. I will complete a new County of Sonoma Extra Help Employees Benefits Enrollment/Change Form within 31 days of a change in this qualification or a change of benefit eligibility. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified. I authorize the County of Sonoma to withhold insurance premiums for the benefits requested in this document in accordance with the applicable Memorandum of Understanding or Board of Supervisor's resolution. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge. For all individuals whom I have indicated a "W" in the "Enroll in Medical Coverage?" column in Section 4 above, I acknowledge I have been given the opportunity to enroll myself and/or my eligible dependents in a County-offered medical plan. I understand I and/or my eligible dependents will not be eligible to enroll in a County-offered medical plan until the plan's next annual enrollment period or in accordance with the loss of eligibility for other group coverage or coverage through Covered CA, as outlined in Section 7 of this form. If I become eligible to make a change during the plan year, I must request enrollment within 31 days of the event.

_____ _____

Employee Signature ***Date***

7. When Changes are Allowed — Change of Status Events and Mid-Year Enrollment Changes Allowed for Employees Under a Health Plan

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code[1]. The chart summarizes most permitted health plan changes.

If you experience the following Event...	You may make the following change(s) within 31 days of the Event…	YOU MAY NOT make these types of changes...
	Life / Family Events	
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new spouse/DP/other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans	• Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Enroll yourself and your dependent children if you or they were previously enrolled in your spouse/DP's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents o Adoption placement papers are required • Change health plans	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.,* child reaches the maximum age for coverage or is no longer a full-time student (dental and/or vision coverage)	• Drop the child who lost eligibility from your health coverage • Child will be offered COBRA	• Change health plans • Drop health coverage for yourself or any other covered individuals
Regain eligibility (e.g. full-time student (dental and/or vision coverage)	• Add child who regained eligibility to your dental and/or vision coverage o Documentation of full-time student status is required	• Add any additional eligible dependents to your dental or vision coverage
Death of a dependent (spouse/DP or child)	• Drop the dependent from your health coverage ☐ • Change health plans	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicare, Medicaid, Medi-Cal, or SCHIP[2]	• Drop coverage for the person who became entitled to Medicare, Medicaid, Medi-Cal, or SCHIP • Add the person who lost entitlement to Medicare, Medicaid, Medi-Cal, or SCHIP o Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible
Change of home address outside of plan service area	• If you are enrolled in an HMO and move out of their service area, then you can elect new coverage	• Does not apply to County Health Plan, dental or vision coverage
	Employment Status Events	
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Drop health coverage • Drop your spouse/DP and other eligible dependents • Change health plans	• Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself o Proof of coverage in the other health plan required	• Change health plans • Add any eligible dependents to your health coverage
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage for health benefits in another group health plan. You or your dependents exhaust COBRA coverage under other group health plan	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans o Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your spouse/DP's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents)	
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase or an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution.	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself • Change health plans to a less expensive plan	• No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.

[1] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.
[2] Have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.

If you experience the following Event...	You may make the following change(s) within 31 days of the Event…	YOU MAY NOT make these types of changes...
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	• Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans	No change is allowed unless the increase in hours results in new eligibility or a significant change in the employer subsidy for medical (not FSA) coverage.
You return from Military Leave	• Enroll yourself, your spouse/DP, and other eligible dependents and/or change health plans	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public Health Insurance Marketplace	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself	

[1] Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.
[1] Have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.

County of Sonoma *Extra Help Employees* Medical Benefits Enrollment/Change Form

Instructions for Completing This Form*--Employees must complete all sections of the form.*

Section 1: Reason for Submitting Form

- Use this form to enroll for coverage as a newly eligible employee, during annual enrollment, or to change your current coverage due to a qualifying life status change (see Section 7).
- 1a: Indicate the reason you are submitting the form and the date of the change(s), as necessary. Check all boxes that apply.
- 1b: Complete this section for any changes to dependent coverage other than annual enrollment and initial eligibility. Newly eligible dependents may only be enrolled within 31 days of the eligibility event.
- 1c: Select a level of coverage for your family

Section 2: Personal Information

- Fill in all information requested. Leave the 4-digit department number blank if you do not know it. If your spouse/domestic partner/dependent(s) is employed by or retired from the County of Sonoma, please indicate in the space provided on the form. Dual coverage is prohibited by the County of Sonoma.

Section 3: Medical Plan Choice

- Select the medical plan you are interested in. Indicate whether you wish to enroll as a newly eligible employee, add coverage for eligible dependent(s), continue current enrollment in medical coverage for yourself and/or your dependent(s), drop/waive medical coverage for yourself and/or your dependent(s), or change your medical plan election during annual enrollment.

Section 4: Employee and Eligible Dependent Information

- Complete the information by first listing yourself and then your eligible dependents and their coverage status. Indicate **(A)** to add coverage for an eligible dependent(s); **(D)** to drop coverage for ineligible dependent(s); **(C)** to continue enrollment in coverage for an eligible dependent(s); **(W)** to waive coverage for an eligible dependent(s) or **(N/E)** if you have listed dependents that are not eligible. Waive coverage if you or your dependent has other group medical coverage or coverage through Covered CA. Drop if there is no other coverage and you are canceling coverage. N/E if you are dropping coverage for someone who no longer meets the eligibility criteria. If coverage is waived and the other group coverage is lost, providing proof of that loss within 31 days gains you eligibility to re-enroll providing all other eligibility criteria are met.
- You MUST indicate whether your dependents are permanently disabled dependents and considered IRS-qualified dependents.

Sections 5: Kaiser Foundation Health Plan Arbitration Agreement

- Complete the Kaiser Foundation Health Plan Arbitration Agreement if enrolling in or already enrolled.

Section 6: Employee Authorization, Waiver of Medical Plan Acknowledgement, and Signature

- Review the Employee Authorization Agreement, Waiver Acknowledgement, and sign and date your form.

Section 7: When Changes are Allowed

Your benefits elections are irrevocable with a few limited exceptions Read this section in its entirety to understand the circumstances under which you are eligible to make changes to your County-offered health plan elections.

Which Forms Do I Need to Complete?

If enrolling or making changes to your medical plan:

Complete the County of Sonoma Extra Help Employees Medical Benefits Enrollment/Change Form. Please retain a copy for your records.

If waiving the medical coverage and not previously enrolled:

Complete the County of Sonoma Extra Help Employees Medical Benefits Enrollment/Change Form. Please retain a copy for your records.

Where to Submit Your Form(s)

County of Sonoma
Human Resources Benefits Unit
575 Administration Dr., Suite 116C
Santa Rosa CA 95403

Questions

Benefits@sonoma-county.org or 707-565-2900