

You must complete all sections of the form. Please sign and date Section 9 for all new benefit enrollments and changes.

Section 1: Reason for Submitting Form

- Use this form to enroll for coverage during annual enrollment, as a newly eligible retiree, or to change your current coverage due to a qualifying change of status event.
- Indicate the reason you are submitting the form and the effective date of the event that led to the change(s), as necessary (e.g. date of marriage, date of retirement). Mark all boxes that apply.
- Newly eligible dependents may only be enrolled within 31 days of the eligibility event.

Section 2: Personal Information

Fill in all information requested. If your spouse/domestic partner/dependent(s) is employed by or retired from the County of Sonoma, please mark the appropriate box(es) on the form. Dual coverage in County sponsored health plans is prohibited.

Section 3: Medical Plan Election

- Indicate whether you wish to make an annual enrollment change, enroll as a newly eligible retiree, add coverage for newly eligible dependent(s), continue current enrollment in medical coverage for yourself and/or your dependent(s), or waive, drop/cancel medical coverage for yourself and/or your eligible dependent(s).
- Select your coverage level and medical plan. If enrolling in a County Health Plan, choose a California or Out of State plan based on the location of your residence for the majority of the year.
- If applicable, list all eligible dependents including spouse / domestic partner in Section 6. List any dependent who is being added, dropped, waived, continuing coverage, or who is being cancelled.
- Complete the *County Health Plan Arbitration Agreement* (Section 7) if you are enrolling in any County Health Plan.
- If enrolling in one of the Kaiser or UHC AARP Medicare plans, also complete applicable enrollment/change forms for the plan. To obtain applicable enrollment forms for:
Kaiser Permanente Senior Advantage Group Election Request Form – Contact Human Resources Benefits Unit at 707-565-2900
AARP® Medicare Supplement Insurance Plans -800-545-1797-Group # 1068 and AARP® MedicareRx Plans 888-867-5575-Group # 3083
- Complete the *Kaiser Foundation Health Plan Arbitration Agreement* (Section 8) if you are enrolling in any Kaiser Permanente Health Plan.

Section 4: Dental Plan Election

- Select DeltaCare USA (California Only) or Delta Dental PPO for your dental plan. If enrolling in DeltaCare USA, please provide the Contract Facility Name and Number information. This information is available by going online to: www.deltadentalins.com
- Indicate whether you wish to make an annual enrollment election, enroll as a newly eligible retiree, add coverage for newly eligible dependent(s), continue current enrollment in dental coverage for yourself and/or your eligible dependent(s), drop dental coverage for yourself and/or your dependent(s), or currently electing not to be covered under a retiree dental plan.
- List all eligible dependents including spouse / domestic partner in Section 6. Indicate who is being added, dropped, continuing coverage. If you are electing not to cover one or more eligible dependents, indicate that with NC.

Section 5: Life Insurance

- Life insurance enrollment is only available at the time of retirement. If you did not enroll at that time, you are not eligible to enroll at a later date, including during annual enrollment.
- Indicate whether you wish to enroll as a newly eligible retiree, continue current enrollment at the same level, or drop life insurance coverage.
- Designate a primary and/or contingent beneficiary(ies) for your life insurance or change your previous designation on file. If newly eligible retiree you must designate a beneficiary.
- Initial in the space provided if you have a life insurance beneficiary designation on file with the County of Sonoma and do not wish to update it.
- Be sure to remember to sign and date Section 9.

Section 6: Eligible Dependent Information

- Complete the information by listing your dependents and their coverage status in medical and dental coverage. Indicate (A) to add coverage for an eligible dependent(s); (C) to continue coverage for an eligible dependent(s); (D) to drop coverage for ineligible dependent(s); (W) to waive coverage for an eligible dependent(s); or (X) to permanently cancel coverage for dependents who are not eligible to waive, or (NC) for not covered.
- You MUST indicate for each dependent whether each is a full-time student, permanently disabled, and/or considered IRS-qualified.
- Indicate whether you and/or your dependents have medical coverage in addition to County-offered coverage (e.g. through your spouse/domestic partner's employer). If so, provide the coverage information requested. This information is required for coordination of benefits.

Section 7: Benefit Plan Provider Agreements

- Sign the *County Health Plan Arbitration Agreement* if you are enrolling in or making changes to a County Health Plan.

Section 8: Benefit Plan Provider Agreements

- Sign the *Kaiser Foundation Health Plan Arbitration Agreement* if you are enrolling in or making changes to a Kaiser Plan.

Section 9: Retiree Authorization and Signature

- Read the Retiree Waiver Policy Acknowledgement. Your signature indicates acknowledgement of the policy only. Coverage is waived by indicating so in sections 3, 4, and/or 6.
- Review the Retiree Authorization Agreement and sign and date your form. A signature and date is always required for all new benefit enrollments and changes.

When Changes are Allowed

Your benefits elections for the plan year are irrevocable with a few limited status change exceptions. Make benefit elections carefully and contact the County of Sonoma Human Resources Benefits unit at benefits@sonoma-county.org or (707) 565-2900 with any questions. Refer to the Common Change of Status Events and the Mid-Year Enrollment Changes Allowed for Retirees Under a Health Plan chart for details.

Please make a copy of this form for your records and return the original Enrollment/Change form to The County of Sonoma Human Resources Department by the enrollment deadline.

575 Administration Dr., Ste #116C, Santa Rosa, CA 95403

Retirees must complete all sections of this form. Please review and follow all instructions for each section of the form before completing.

Section 1a: Reason for Enrollment/Change	Section 1b: Add/Drop Dependent Coverage	Internal / Vendor Use Only
Mark all boxes that apply and enter date: Event Date: _____ <input type="checkbox"/> Annual Enrollment (Event date: June 1) <input type="checkbox"/> New Retiree <input type="checkbox"/> Newly Medicare Eligible Retiree <input type="checkbox"/> Newly Medicare Eligible Dependent <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Moved Out of Service Area <input type="checkbox"/> Cancel Medical Coverage (Irrevocable) <input type="checkbox"/> Cancel Dental Coverage <input type="checkbox"/> Life Insurance Beneficiary Change <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Previous Name: _____	Mark all boxes that apply and enter date: Event Date: _____ <input type="checkbox"/> ADD Newly Acquired/Eligible Dependent(s) due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> QMCSO <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Dependent(s) newly eligible for <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> DROP/WAIVE Dependent(s): _____ Reason _____ Initial here _____ if dropping coverage for an <u>eligible</u> dependent while retiree remains enrolled. County policy, Salary Resolution, 95-0926, prohibits future re-enrollment of a dependent child.	Date of Retirement: _____ Benefits Effective Date: _____ Medicare: <input type="checkbox"/> YES <input type="checkbox"/> NO Retiree Medical Eligibility: <input type="checkbox"/> Post '90 10-20 <input type="checkbox"/> Post '90 20+ <input type="checkbox"/> Pre 1990 <input type="checkbox"/> Post 2009 Eligible Dependents @ Full Cost: _____ Waiver Received: <input type="checkbox"/> YES <input type="checkbox"/> N/A HR Initials: _____ Date: _____ eP Entry: _____ Review: _____

Section 2: Retiree's Personal Information			
Last Name	First Name	M.I.	Social Security Number
Home Address	City, State, Zip Code		Date of Birth (MM-DD-YY)
Phone Number(s)	E-mail	Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
Is your spouse/domestic partner/dependent(s) an employee of the County of Sonoma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s): _____			
Is your spouse/domestic partner a retired employee of the County of Sonoma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s): _____			Gender (Retiree): <input type="checkbox"/> Male <input type="checkbox"/> Female

Section 3: Medical Plan Election (Check all that apply; complete Section 6.)
Mark all boxes that apply. <input type="checkbox"/> ANNUAL ENROLLMENT CHOICE ONLY -I am electing to CHANGE MY MEDICAL PLAN ELECTION . <input type="checkbox"/> I am a NEWLY ELIGIBLE RETIREE making my medical plan election. <input type="checkbox"/> I am electing to ADD medical coverage for my newly eligible dependent(s). <input type="checkbox"/> I am electing to CONTINUE current enrollment in retiree medical coverage for myself and/or my eligible dependent(s). <input type="checkbox"/> I am electing to WAIVE medical coverage for myself and/or my dependent(s) as I/we have other group coverage. By waiving, I will not have the option of re-enrollment at anytime unless I qualify under the limited provisions as defined in the Salary Resolution 95-0926. <i>If waiving medical coverage for yourself and/or your eligible dependent(s), you must also complete the Waiver of Medical Plan Acknowledgement (Section 9).</i> <input type="checkbox"/> I am electing to DROP/CANCEL medical coverage for myself and/or my dependent(s). (Applies to a current retiree not eligible to waive medical coverage). <i>I understand that by cancelling my medical coverage, I forfeit my opportunity to enroll in a County offered medical plan in the future.</i>

Select your desired Level of Coverage and Medical Plan	
Level of Coverage: <input type="checkbox"/> SELF <input type="checkbox"/> SELF + 1 DEPENDENT <input type="checkbox"/> SELF + 2 OR MORE DEPENDENTS	
Retirees without Medicare: <input type="checkbox"/> County Health Plan PPO - CA (175130M053) <input type="checkbox"/> County Health Plan PPO - Out of State (175130M059) <input type="checkbox"/> County Health Plan EPO - CA (175130M102) <input type="checkbox"/> County Health Plan EPO - Out of State (175130M106) <input type="checkbox"/> Kaiser Permanente HMO - CA (9072-0000) <input type="checkbox"/> Kaiser Permanente HMO - Northwest (5613-002 AA) <input type="checkbox"/> Kaiser Permanente HMO - Hawaii (03003-058-86)	Retirees with Medicare: <input type="checkbox"/> County Health Plan PPO - CA (175130M054) <input type="checkbox"/> County Health Plan PPO - Out of State (175130M060) <input type="checkbox"/> County Health Plan EPO - CA (175130M103) <input type="checkbox"/> County Health Plan EPO - Out of State (175130M107) <input type="checkbox"/> Kaiser Permanente Senior Advantage - CA (9072-0000) * <input type="checkbox"/> Kaiser Permanente Senior Advantage - Northwest (5613-002 AA)* <input type="checkbox"/> Kaiser Permanente Senior Advantage - Hawaii (03003-058-86) * <input type="checkbox"/> UnitedHealthcare AARP Medicare Supplement (1068) * and Medicare Rx (3803) * *Additional Enrollment Form Required

Section 4: Dental Plan Election (Check all that apply; complete Section 6.)

- Select your dental plan choice: **Delta Preferred Option** (3136-0001)
 DeltaCare USA (00247-0001) - Enter contract facility name & number below
Contract Facility Name: _____ **Facility #:** _____

Mark all boxes that apply.

- ANNUAL ENROLLMENT** choice only-I am electing to **CHANGE** my dental plan election.
 I am a **NEWLY ELIGIBLE RETIREE** making my dental plan election.
 I am electing to **ADD** dental coverage for my newly eligible dependent(s).
 I am electing to **CONTINUE** current enrollment in dental coverage for myself and/or my eligible dependent(s).
 I am electing to **DROP** dental coverage for myself and/or my dependent(s).
 I am currently **NOT COVERED** under a retiree dental plan and will not be enrolling at this time.

<p>Internal Use Only</p> <p>Effective Date: _____</p> <p>If blank, effective date is the same as Benefits Effective Date on Page 1.</p>

Section 5: Life Insurance (Complete this section per instructions; sign and date Section 9 for all new benefit enrollments and changes.)

HARTFORD GROUP POLICY #: GL-673199

- I am a **NEWLY ELIGIBLE RETIREE** electing to **ENROLL** in life insurance coverage in the amount of \$10,000
 I am electing to **CONTINUE** my current enrollment in life insurance coverage in the amount of \$2,000
 I am electing to **CONTINUE** my current enrollment in life insurance coverage in the amount of \$10,000
 I am electing to **DROP** current enrollment in life insurance coverage
 I did not enroll in life insurance at the time I retired and am therefore **NOT ELIGIBLE** to make any life insurance election

Retiree Basic Life Insurance (Initial here _____ if you have a life insurance beneficiary designation on file with the County of Sonoma and do not wish to update it.)

You must designate a beneficiary(ies) to receive payment of this benefit in the event of your death. Indicate your beneficiary information below, only if you do not currently have a beneficiary on file or you wish to change your current beneficiary designation. If you need more space, request a Beneficiary Designation Form from Hartford Life at 800-523-2233 or from County of Sonoma Human Resources Benefits Unit at 707-565-2900 or benefits@sonoma-county.org

Primary Beneficiary Full Name	Address	SSN	% of Benefit	Relationship	Birth Date
Contingent Beneficiary Full Name (Optional)	Address	SSN	% of Benefit	Relationship	Birth Date

If you are married or divorced, consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by the County of Sonoma Human Resources Department.

Section 6: Eligible Dependent Information (List ALL eligible dependents including spouse/domestic partner. Attach an additional sheet to list more than six dependents.)

Full-time student status is required to enroll dependents 19 and over in County-offered dental coverage. Disabled over-age dependents must meet the eligibility requirement for permanently disabled over-age dependent(s). Refer to the plans' evidence of coverage booklets or summary plan descriptions for more information. Complete the information below and indicate your choice for your dependent(s). **A=Add coverage, C=Continue coverage, D=Drop coverage, W=Waive coverage, X=Cancel coverage, or NC=Not Covered**

Dependent Name (First, MI, Last)	Gender (M/F)	Date of Birth (MM-DD-YY)	Social Security Number	Relation ship	Enroll in Medical Coverage? (Enter A, C, D, W, or X)	Enroll in Dental Coverage? (Enter A, C, D, or NC)	Full-Time Student? (Y/N)	Permanently Disabled Dependent? (Y/N)	Tax Purposes Only Place a ✓ below to indicate dependent status	
									IRS Qualified	Non-IRS Qualified

This information is required for coordination of benefits. Do you and/or your eligible dependents listed above have medical coverage in addition to County-offered coverage (e.g., through your spouse/domestic partner's employer or an individual policy?) Yes No If yes, enter the coverage information below.

Individual's Name	Subscriber's Name	Name of Medical Plan

Section 7: County Health Plan Agreement (If electing one of the County Health Plans, sign this agreement.)

County Health Plan PPO, County Health Plan EPO

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

The following provision does not apply to class actions: IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Retiree Signature Required for County Health Plan

Date

Section 8: Kaiser Permanente Plan Agreement (If electing one of the Kaiser Health Plans, sign this agreement.)

Kaiser Permanente Plan

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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*.

Retiree Signature Required for Kaiser Permanente HMO Plan or Kaiser Permanente Senior Advantage Plan
California Retirees Only

Date

Section 9: Retiree Authorization and Signature (Retiree signature and date is required for all new benefit enrollments and changes.)

Retiree Waiver Policy Acknowledgement

Retiree medical coverage provisions are outlined the County of Sonoma Salary Resolution No 95-0926. In order to maintain eligibility for a County contribution and to participate in a County-offered retiree medical plan, an eligible retiree must enroll in a County offered retiree medical plan at the time of retirement unless the retiree waives medical insurance coverage for themselves and/or the retiree's eligible dependent(s). The option to waive coverage is a onetime option available only at the time of retirement or upon initial eligibility for newly eligible dependents. A retiree who waives medical coverage will be allowed to re-enroll themselves and any eligible dependent(s), upon a limited number of conditions, has no annual enrollment rights, and is only eligible to waive if covered by another group medical plan. If not covered by another group medical plan, the retiree may drop/cancel coverage with no re-enrollment options.

By signing below, I acknowledge that I have been given the opportunity to enroll or waive coverage for myself and my eligible dependents listed in Section 6 in a County-offered medical plan pursuant to the eligibility criteria outlined in the Salary Resolution and the medical plan's documents. I understand I will be allowed to enroll myself and/or my eligible dependents in a County offered retiree medical plan, if eligibility requirements are met, and I enroll and submit documentation within 31 days of the event and no later than 60 day after becoming Medicare eligible. I acknowledge my eligible dependent child(ren) will only be allowed to re-enroll at the time I re-enroll.

If I become eligible to make a change during the plan year, I must request the change within 31 days of the event.

I declare under penalty of perjury that:

I agree to comply with the terms of the benefits group contracts in which I am enrolled. I authorize the Sonoma County Employees' Retirement Association (SCERA) to withhold all insurance premiums in excess of any County contribution for the benefits requested in accordance with the applicable Board of Supervisor's Resolution. All eligible dependents listed meet the medical plan's eligibility requirements. I will complete a new Medical Benefits Enrollment/Change Form within 31 days of a change in benefit eligibility. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge. I authorize SCERA to release to the County of Sonoma all information reasonably necessary to evaluate or administer my retiree health benefits

Retiree Signature

Date

County of Sonoma- Human Resources Department
A Summary of the most Common Change of Status Events and the Mid-Year Enrollment Changes
Allowed for Retirees Under a Health Plan

This chart is only a summary of some of the permitted health plan changes and is **not** all inclusive.

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...
<i>Life / Family Events</i>		
Marriage or Commencement of Domestic Partnership (DP)	<ul style="list-style-type: none"> • Enroll in or waive coverage for your new spouse/DP and other newly eligible dependents¹ • Waive coverage for newly eligible dependents if your coverage is also waived¹ • Change health plans 	<ul style="list-style-type: none"> • Waive health coverage for yourself and previously eligible children¹ • Enroll if not already enrolled
Divorce or Termination of Domestic Partnership (DP)	<ul style="list-style-type: none"> • Cancel coverage for your spouse/DP • Enroll yourself and your dependent children if you or they were previously enrolled in your spouse/DP's plan and only if a signed waiver is on file • Cancel coverage for dependent children² 	<ul style="list-style-type: none"> • Change health plans
Gain a child due to birth or adoption	<ul style="list-style-type: none"> • Enroll in or waive coverage for the newly eligible dependent¹ <ul style="list-style-type: none"> ◦ Adoption placement papers are required • Change health plans 	
Previously ineligible child requires coverage due to a QMCSO	<ul style="list-style-type: none"> • Add child named on QMCSO to your health coverage (enroll yourself, if eligible and waiver is on file) • Change health plans, when options are available if necessary to accommodate the child named on the QMCSO 	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Drop the child who lost eligibility from your health coverage 	<ul style="list-style-type: none"> • Change health plans
Death of a dependent (spouse or child)	<ul style="list-style-type: none"> • Drop the dependent from your health coverage • Enroll in health coverage if the event resulted in the loss of other group coverage and if a waiver is in place • Change medical plans 	
Retiree has become entitled to Medicare	<ul style="list-style-type: none"> • Change medical plans • Last opportunity to enroll yourself, spouse, and dependent children, if previously waived. Eligibility for coverage will be permanently canceled if no enrollment within 60 days of Medicare eligibility 	
Covered dependent has become entitled to (or lost entitlement to) Medicare, Medicaid, or SCHIP	<ul style="list-style-type: none"> • Cancel coverage for the person who became entitled to Medicare, Medicaid, or SCHIP² • Add the person who lost Medicare, Medicaid, or SCHIP entitlement, if eligible and previously waived <ul style="list-style-type: none"> ◦ Documentation required 	<ul style="list-style-type: none"> • Change health plans • Drop health coverage for yourself or any other individuals who are not newly Medicare, Medicaid, or SCHIP eligible
Change of home address outside of plan service area	<ul style="list-style-type: none"> • Change health plans if you are enrolled in a medical or dental HMO and move out of their service area 	
Death of retiree	<ul style="list-style-type: none"> • Eligible dependents must enroll at the time of the event or permanently lose eligibility 	<ul style="list-style-type: none"> • Surviving dependents cannot continue to waive coverage
<i>Employment Status Events</i>		
You retire, transferring from active benefits to retiree benefits	<ul style="list-style-type: none"> • Change medical plans • Enroll in a retiree dental plan • Waive coverage for self and/or dependents covered on your plan at the time of retirement provided they have other group coverage (One time option) • Enroll dependents who are currently enrolled or listed as waived on your active employee medical coverage 	<ul style="list-style-type: none"> • Add dependents to retiree medical plan not already enrolled in active employee medical
Spouse obtains health benefits in another group health plan	<ul style="list-style-type: none"> • Cancel coverage for spouse² 	<ul style="list-style-type: none"> • Change health plans • Waive health coverage¹
Spouse loses employment or otherwise loses coverage for health benefits in another group health plan (Proof of loss of other coverage is required)	<ul style="list-style-type: none"> • Enroll your spouse in your health plan, if previously waived due to other group coverage • Enroll your spouse, yourself, and/or eligible dependent children in your medical plan if previously waived due to previous coverage under your spouse's group plan • Change medical plans 	

Notes:

Dropping Eligible Dependents:

Dependents dropped from coverage have limited or no re-enrollment rights. Review Article 16 of the Salary Resolution carefully before dropping coverage for eligible spouse and/or dependents.

Waiving Coverage (when covered by other insurance):

Medical coverage can be waived only at the time of retirement or within 31 days of initial eligibility for newly eligible dependents. Re-enrollment is limited. Read Article 16 and the waiver language on the Retiree Benefits Enrollment and Change Form carefully before waiving coverage.

Medicare Enrollment Requirements:

Medicare requirement: Medicare eligible retirees and/or Medicare eligible dependents must complete and sign enrollment paperwork the month prior to the effective date of the Medicare eligibility and provide a copy of their Medicare card(s) demonstrating enrollment in Medicare Part A and B.

Continuation Rights through COBRA:

Not available to retirees or dependents of retirees. COBRA is available to covered active employees and their dependents at the time of retirement, upon losing active coverage.

Permanently Cancel All Coverage:

You may permanently cancel coverage at any time. However you will give up all reenrollment rights. Read Article 16 of the Salary Resolution carefully before cancelling coverage.

Effective Dates- The above benefit election changes are effective as follows:
Canceling Coverage: Effective date of change is generally the last day of the month after the event that allowed the change. E.g., Spouse obtains other group coverage on the 1 st of the month. Coverage for spouse ends on the last day of the prior month.
Adding newly eligible dependent: Effective date of change is generally the first of the month following or coinciding with the event that allowed the change. E.g., Married on 1 st of the month. Coverage for new spouse is effective on the 1 st of the same month. Married on the 2 nd of the month. Coverage for new spouse is effective on the 1 st of the following month.
New Retirees: Effective on the 1st of the month following or coinciding with the date of retirement. E.g., Retired July 1st. Employee coverage ends June 30 th , retiree coverage is effective on July 1st. Retired July 9th. Employee coverage ends July 31 st , retiree coverage is effective August 1st.
Exception:
Birth/Adoption: Effective on the 1st of the month following date of birth/adoption. Medical plans will cover a newborn under the subscriber’s coverage from date of birth through the end of the birth month. Submit paperwork to the Human Resources Benefits Unit early and no later than 31 days from the date of birth to ensure medical coverage for the child.

All rules above apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

Contact Information: County of Sonoma, Human Resources Benefits Unit, 707-565-2900, benefits@sonoma-county.org

¹ Waiving retiree medical for a newly eligible dependent is a one-time only option at the time of the enrollment of the newly eligible dependent

² Eligible dependents not covered when the retiree is covered are not eligible for re-enrollment at any time in the future, not even upon the loss of other group coverage, per Salary Resolution.