County of San Mateo
Employee Benefits Enrollment Form

Employee Name Last First MI

Address (No.& Street)

Address (City, State & Zip Code)

Birthdate **Employment Date** **Soc. Sec. No.**

Home Phone **Work Phone**

Election of Coverage

Basic Life Insurance: (County Paid) **Please complete beneficiary card. (Required)**

Supplemental Life: (Optional, Employee Paid, Duplicate Coverage not allowed) ☐ No ☐ Yes (enrollment card **Required**) ☐ Self ☐ Spouse ☐ Child(ren)

Short Term Disability: (Optional, Employee Paid) Complete the enrollment form. State Disability is not available to Management, Confidential, DAs, DSA, PDA, or Operating Engineers

☐ **Basic** (7 months only if SDI eligible) ☐ **Expanded** (Management, Confidential and D.A.s)

Health Insurance: ☐ Self ☐ Emp+1 ☐ Family

☐ **Aetna *** ☐ **Blue Shield POS Plan*** ☐ **Kaiser** ☐ I am declining health coverage during the initial enrollment period.

☐ **Operating Engineers**-Comprehensive Plan (Building Trades Council employees only)

*If you enroll in Aetna or Blue Shield you and your family must select a Primary Health Physician.

Dental Insurance: ☐ Self ☐ Emp +1 ☐ Family

MANDATORY - Must choose one: ☐ **Blue Shield County Dental Plan** ☐ **PMI (Delta Managed Care)** (You must indicate provider #)

Vision Insurance: (Automatic Enrollment) List dependents below.

Requesting Coverage For:

	Last Name	First Name	MI	DOB	Sex	Soc.Sec.No.	Health Physician**	Dental Provider	(Enter Y or N) Hlth	Dntl	Vis
Emp											
Spouse											
D/Part*											
Child*											
Child*											
Child*											

***Requies an Affidavit of domestic Partnership. Children over age 19 require Young Adult Dependent Affidavit.**

**HAVE YOU BEEN SEEN BY THIS PROVIDER BEFORE? ___ Yes ___No

If you or any of your dependents are covered by another carrier, please provide the following information:

Health Carrier _____ **Policy No**._____

Dental Carrier _____ **Policy No**._____

Are you, your spouse or any dependent covered by medicare? ☐ Yes ☐ No

Name of Medicare Member_____Effective Date of Coverage: Medicare Part A:_____Medicare Part BI:_____

Authorization. I understand the Health Care Plan I selected may require binding arbitration rather than a court trial to resolve any claim, including a claim for malpractice, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the plan, or against a provider of goods or services affiliated with the plan, or against the employees, partners, or agents of such providers, if the plan I have selected has such a requirement. I agree to abide by it. I understand that this agreement means that I will not be entitled to a court trial on such claims. I apply for membership for persons listed above and agree that we shall abide by the provisions of the membership contract for the Health Care Plan in which we have enrolled. I authorize my employer to deduct from my pay the required contribution, if any toward the cost of my coverage. I acknowledge that my failure to elect medical coverage during the initial enrollment period permits the health benefit plans offered above to impose an exclusion from coverage altogether for a period of up to 12 months. I have read and understand the late enrollee waiver on the reverse side of this form. **I understand that benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely**.

RETURN TO HRD 133

Signature _____ **Date** _____

FOR COUNTY USE ONLY			**CLASS CODE:**	**TYPE:**	**BEN CODE:**
PPB:	LIFE	STD	HEALTH	DENTAL	VISION
EFFECTIVE DATE OF COVERAGE					
EMP.CONTRIBUTION					
CNTY. CONTRIBUTION					
POST DATE					
RETRO ADJUSTMENTS					