

Retired Annuitants – Medical Insurance Enrollment/Change Form

Return completed form to:
City of Stockton – Human Resources (HR) Department
22 E. Weber Avenue, Suite #150, Stockton, CA 95202
Phone: (209) 937-8233, Fax: (209) 937-5702

HR USE ONLY

Entered: _____

Verified: _____

ENROLLMENT/CHANGE REASON

NEW HIRE OPEN ENROLLMENT QUALIFYING LIFE EVENT* COURT ORDERED

EFFECTIVE DATE _____

(Will be verified by HR staff)

EMPLOYEE INFORMATION

Last Name _____ First Name, MI _____ Female Male

Social Security Number _____ Date of Birth _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

E-mail Address _____

DEPENDENTS

Action	Dependent's Full Name	Relationship	Date of Birth	Social Security #	F/M	(If Applicable)
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP

***Note:** Proper and timely receipt of documentation is required when adding or removing dependents from a qualifying life event, such as: Birth, marriage, registered domestic partnerships, divorce, adoption, legal guardianship, Qualified Medical Child Support Order (QMCSO), etc. If you have a current QMCSO, you must provide verification from the issuing agency before making any changes to the health insurance benefits of the child(ren) named on the QMCSO.

You must provide the form and supporting documentation in a timely manner to receive benefits. In most situations, you are required to submit documents within 31 days of the life changing event, and benefits will begin the first of the month following the date all required documents have been received. Please refer to the appropriate plan document and City directive for specific eligibility requirements.

CITY OF STOCKTON HEALTH PLAN OPTIONS AND MONTHLY PREMIUM RATES

The health plan listed below is offered to Retired Annuitants at full premium cost. The City of Stockton does not contribute to the cost of the medical plan. Dental and vision benefit options are not offered to Retired Annuitants.

MEDICAL: SELECT TIER LEVEL OR OPT OUT OF COVERAGE		
TIER	<input type="checkbox"/>	KAISER
Employee Only	<input type="checkbox"/>	\$631.45
Employee + One	<input type="checkbox"/>	\$1,136.60
Employee + Family	<input type="checkbox"/>	\$1,515.46
Opt Out*	<input type="checkbox"/>	I decline medical and prescription coverage

***MEDICAL OPT OUT ACKNOWLEDGEMENT (if applicable)**

By checking the box and signing this form, you are acknowledging that you were offered medical and prescription coverage through the City of Stockton for you and your eligible dependents, and you have declined to enroll in this coverage.

PAYROLL DEDUCTIONS: Health benefit premiums (if applicable) will be deducted pre-tax from each paycheck under the City of Stockton's Section 125 Plan umbrella. The employee may specifically request a post-tax deduction by providing a written statement, under separate cover. By signing below, you are authorizing the City of Stockton to deduct pre-tax payroll premiums for health benefits. This deduction is based on the cost of benefits as established by the Health Actuarial Report.

INELIGIBLE CLAIMS OR PREMIUMS ACKNOWLEDGEMENT: *In the event that the City of Stockton pays medical claims or premiums for an ineligible dependent, the employee will be required to refund the City for the full cost of the claim and premium paid. This may occur when there has been a change in the marital/registered domestic partnership status, not reported to the City of Stockton's Benefits Division. **By signed below, I certify that the information provided herein is true and accurate to the best of my knowledge, and I understand all of the acknowledgements and disclaimers listed in this document.***

Employee Signature: _____ **Date:** _____