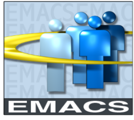

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

VISION PLAN ENROLLMENT/CHANGE FORM

FOR HR USE ONLY			
Keyed By (Employee ID)	Date	Pay Period Effective	Effective Date

☐ EXEMPT ☐ NURSES ☐ SAFETY MANAGEMENT/SUPERVISORY
☐ FIREFIGHTER LOCAL 935 ☐ PROBATION ☐ SPECIALIZED PEACE OFFICER
☐ NON-REPRESENTED ☐ SAFETY ☐ SPECIALIZED PEACE OFFICER SUPERVISORY

Must print in Black or Blue ink ONLY

☐ NEW EMPLOYEE ☐ CHANGE IN STATUS ☐ OPEN ENROLLMENT

EMPLOYEE INFORMATION

Employee ID	Last Name, First Name, MI	Social Security Number	Check One ☐ Male ☐ Female	Date of Birth
Mailing Address — Check here if new address ☐	City	State	Zip Code	Telephone Home Work
Residential Address — Check here if new address ☐	City	State	Zip Code	Date of Hire
Department				

NEW ENROLLMENT ONLY

IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME, LIST ALL PERSON(S) TO BE COVERED AND PROVIDE APPROPRIATE DOCUMENTATION FOR EACH

Last Name	First Name	Sex	Date of Birth	Social Security Number	Relationship
Spouse/Domestic Partner:		☐ M ☐ F			
Children:		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			

ENROLLMENT CHANGES ONLY

IF YOU ARE ADDING OR DELETING DEPENDENT(S), COMPLETE THIS SECTION AND PROVIDE APPROPRIATE DOCUMENTATION

	Last Name	First Name	Sex	Date of Birth	Social Security Number	Relationship
☐ Add ☐ Delete	Spouse/Domestic Partner:		☐ M ☐ F			
☐ Add ☐ Delete	Children:		☐ M ☐ F			
☐ Add ☐ Delete			☐ M ☐ F			
☐ Add ☐ Delete			☐ M ☐ F			
☐ Add ☐ Delete			☐ M ☐ F			
☐ Add ☐ Delete			☐ M ☐ F			
☐ Add ☐ Delete			☐ M ☐ F			

IF ADDING SPOUSE/DOMESTIC PARTNER, INDICATE DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, INDICATE DATE OF DIVORCE/DISSOLUTION OF DOMESTIC PARTNERSHIP OR DEATH.	Month	Day	Year	☐ Married/Domestic Partnership ☐ Divorce/Dissolution of Domestic Partnership ☐ Death

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QUALIFYING CHANGE IN STATUS EVENT

I understand that I may elect to add or delete eligible dependent(s) to my vision plan if a "Qualifying Change in Status Event" occurs.

Examples of qualifying events are:

- Marriage, domestic partnership, divorce, dissolution of domestic partnership or legal separation of the member
- Birth or adoption of a child by the member
- Death
- Termination or commencement of a spouse's or domestic partner's employment
- Over-Age Dependent (disabled child over age 26)
- Unpaid leave of absence taken by the member's spouse or domestic partner
- A significant change in the vision coverage of the member or dependent(s) attributable to the spouse's/domestic partner's employment, such as offering insurance for the first time or a significant increase or decrease in premium cost
- Medicare entitlement

To add or delete dependent(s), I understand that I must submit a new Vision Plan Dependent Enrollment-Change Form and a Premium Deduction Election form within 60 days of a Qualifying Change in Status Event. If I do not submit these forms within 60 days, my request may be denied. All requests must be consistent with the stated qualifying event.

I understand that if at any time my or my family's eligibility changes, I will notify Human Resources Department - Employee Benefits and Services Division (HR-EBSD) or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit deductions. For example, if I get divorced I am required to remove my ex-spouse from County-sponsored Benefit Plans.

DEPENDENT AFFIDAVIT

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Employee Benefits Guide, applicable Memoranda of Understanding, and plan eligibility requirements by carrier. A comp lete list of dependent eligibility criteria may be found on the HR-EBSD internet and intranet sites.
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistenci es discovered with respect to enrollment and eligibility will be investigated and I may be subject to disciplinary action up to and including termination of employment.
- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
  - notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage
  - provide supporting documentation upon request of HR-EBSD
- I am responsible for any applicable cost incurred for obtaining supporting documentation.
- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or hav e covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf. Additionally, I will reimburse the County for any portion of the employer contribution paid to the carrier(s) for the period of time coverage was provided for my ineligible dependent.
- Failure to notify HR– EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for c overage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as o f this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, applicable Memoranda of Understanding, and related state and/or federal law(s).

Employee Signature	Date

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