☐ OPEN ENROLLMENT
☐ NEW RETIREE
☐ OTHER:_____

# RETIREE MEDICAL ENROLLMENT APPLICATION
## SAN JOAQUIN COUNTY SELF-FUNDED INSURANCE PLANS

☐ ADD DEPENDENT
☐ DELETE DEPENDENT
*DATE/REASON: _____

_____

**Indicate Plan** ☐ **CMCP-R** ☐ **RETIREES OUT OF AREA** **MEMBER ID** _____

### 1A Employee Information

| **Employee Name** LAST FIRST MI | **Date of Birth** / / |
|---|---|
| **Gender** ☐ Male ☐ Female; **Mailing Address** STREET CITY STATE ZIP | |
| **Home Phone** ( ) | **Business Phone** ( ) / **Social Security Number** |
| **Primary Care Physician Selection** Required for CMCP-R<br>Please list physician's **full** name: Current Patient? ☐Yes ☐No | |

### 2A Dependent Information
If any dependents listed below are residing at a different address than specified in 1A, place a check in the column provided if you would prefer to have their identification card and plan information mailed to the address specified in section 2B.

| ✓ | **Name** LAST FIRST MI | **Date of Birth** | **Relationship** | **M/F** | **Social Sec#** | **Primary Care Physician** | Current Patient? Y/N |
|---|---|---|---|---|---|---|---|
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### 2B Dependent's Alternate Address

**STREET** **CITY** **STATE** **ZIP**

**Status of Dependents over the age of 26**
☐ Covering a disabled dependent 26 years or older. Please attach a statement from physician stating disability.

### 3A Other Health Insurance or Coverage

| Health Insurance Company | Name of Subscriber | |
|---|---|---|
| Address of Carrier STREET CITY STATE ZIP | | Phone number of Carrier ( ) |
| SSN/Policy Number | Group Number | Effective Date |
| List Names Covered Under This Plan | | |
| **Medicare Coverage**<br>Name of Recipient: ☐ Part A ☐ Part B<br>Name of Recipient: ☐ Part A ☐ Part B | | |

* **All other mid-year additions and deletions of dependents must be the result of a qualifying event, such as marriage, divorce, birth, adoption, death, change in spouse's employment, change in child's student status, child reaching maximum age.**
* **Enrollment changes must be made within 60 days of the qualifying event.**

I have read and understand the terms on the reverse of this application. My signature below indicates my acceptance of these terms and that the information I have entered is true and correct.

_____ _____
Retiree's Signature Date Signed

**County Use Only**
Effective Date: Health Plan ID#

# IMPORTANT INFORMATION

**Retiree Responsibility**

I understand that as my dependents become ineligible, resulting in a possible reduction in premium, it is my responsibility to notify the SJCERA of such fact, and as new dependents become eligible, it is my responsibility to notify the SJCERA within 60 days of their birth, adoption or guardianship in the case of children, or marriage in the case of a new spouse.

**Medical Release**

I, on my behalf and on behalf of my Family Member(s) listed on this enrollment form, hereby authorize the Plan to release information to official government agencies when required under appropriate Federal and State legislation and regulation, or pursuant to legal agencies/providers for the provision of necessary health care services and/or administrative services under the Plan. This Authorization shall remain in effect for the term of my or my family member(s) enrollment.

**Plan Requirements**

I, on my behalf and on behalf of my Family Member(s) listed on this enrollment form, agree to be bound by the benefits, deductions, surcharges, exclusions, and other terms of the Plan group agreement as the group agreement is amended.

**Payroll Deductions**

I hereby authorize SJCERA to deduct from my earnings the amount required to cover my share of premium, if any. If my earnings are not sufficient, it is my responsibility to make arrangements with SJCERA to cover the premium by making direct payments to SJCERA.