RETIREE BENEFITS CHANGE FORM

County of San Mateo
Human Resources Department

- **FORM MUST BE SUBMITTED WITHIN 31 DAYS FROM CHANGE/QUALIFYING EVENT**
- **ALL CHANGES EFFECTIVE 1st OF THE FOLLOWING MONTH AFTER THE CHANGE FORM HAS BEEN RECEIVED**
- **MEDICARE RECIPIENTS MUST SUBMIT MEDICARE APPLICATION WITH COPY OF MEDICARE CARD IN ORDER TO MOVE INTO A MEDICARE MEDICAL PLAN**

SECTION 1. RETIREE INFORMATION

Name (Last, First, M.I.):	Social Security Number:	Date of Birth:
Home Address (Number, Street, Apt#):	City:	State: Zip Code:

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ Domestic Partner ☐ Widow

Phone Number:

Email Address:

SECTION 2. REASON FOR CHANGE

Effective Date of Change _____

☐ Qualified Life Event

☐ Cancel Coverage[1]

Qualified Life Event (Check One)

☐ Marriage / Domestic Partner[2]
☐ Divorce, Separation or Death
☐ Birth or Adoption[2]
☐ Change of Spouse's Employment
☐ Name Change/Address Change
☐ Medicare Eligibility
☐ Sick Leave Hour Change *note in comments*
☐ OTHER _____

[1]If you cancel Medical coverage, you are waiving your rights to the County's plan and will not be allowed to re-enroll.
[2]Marriage Certificate, Domestic Partner Affidavit, Birth Certificate required.

SECTION 3: COVERAGE ELECTION:

MEDICAL ☐ WAIVE[1] ☐ Alternative Health Plan

Under 65 Plans
☐ Kaiser HMO
☐ Kaiser HDHP
☐ Blue Shield HMO
☐ Blue Shield HMO TRIO
☐ Blue Shield PPO
☐ Blue Shield PPO HDHP
☐ Op Eng Kaiser
☐ Op Eng PPO

Over 65 Plans (Medicare)
☐ Kaiser Sr. Advantage
☐ Blue Shield PPO
☐ Secure Horizons HMO

Coverage Election
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

DENTAL ☐ WAIVE
☐ Voluntary Delta DHMO
☐ Voluntary Cigna DPPO

Coverage Election
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

VISION ☐ WAIVE
☐ Voluntary Vision Service Plan

Coverage Election
☐ Retiree Only
☐ Retiree + 1
☐ Retiree + Family

RETIREE COMMENTS

RETIREE BENEFITS CHANGE FORM

County of San Mateo
Human Resources Department

Add Delete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth	Gender
	☐ Spouse ☐ Domestic Partner				☐ M ☐ F
	Child 1				☐ M ☐ F
	Child 2				☐ M ☐ F
	Child 3				☐ M ☐ F

(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)

Have you included stepchildren as dependents? ☐ NO ☐YES - If "yes" indicate name/s: _____

Do your stepchildren reside with you? ☐ NO ☐ YES Are they dependent upon you for support and maintenance? ☐ NO☐ YES

SECTION 4: FINAL SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read, understand, and agree to the terms and conditions above.

Signature of Retiree: _____ Date: _____

Enrollment Form Submission Instructions

1) **Submit the completed form to the Benefits Office either by**
   a) Fax at (650) 599-1573
   b) Email to benefits@smcgov.org
   c) Mail to 455 County Center, Redwood City, CA 94063
2) **Please print a copy of this form, sign and retain for your records.**

HR-BENEFITS USE ONLY

Effective Date	Participant ID (CSM)	
Division Code Change ☐ No ☐ Yes: R____ to R____	EFT Needed ☐ No ☐ Yes If yes, Attached?	
Sick Hour Contribution Change ☐ No ☐ Yes _____ to _____	SHARET Updated (Date/Initial)	
Medicare Agreement Received ☐ No ☐ Yes ☐ N/A	Alternative Health Plan Agreement Received ☐ No ☐ Yes ☐ N/A	
Entered in BCC (Date/Initial)	Confirmed in BCC (Date/Initial)	Confirmation Letter Mailed (Date/Initial)
NOTES:		