



**SUPERIOR COURT OF CALIFORNIA,
COUNTY OF KERN**

**GROUP ENROLLMENT/CHANGE FORM
EXTRA HELP EMPLOYEES - 2021**

HEALTHCOMP

P.O. BOX 45018 FRESNO CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

- New Enrollment
- Name/Address Change
- Reinstatement
- Rehire

- Annual Enrollment
- Change Enrollment
- Decline Coverage
- Termination

(Shaded area for office use only)

PART 1 EMPLOYEE INFORMATION										
EMPLOYER SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN				PLAN CHOICE <input checked="" type="checkbox"/> PPO		GROUP NUMBER E-50		Benefit Type(s): <input type="checkbox"/> Medical/Rx		
EMPLOYEE LAST FIRST MI			SOCIAL SECURITY NO.			EFFECTIVE DATE				
ADDRESS STREET CITY STATE ZIP CODE			HOME PHONE ()		BIRTHDATE MO DAY YEAR		MEDICAL			
HIRE DATE		STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED		IF RETIRED, DATE OF RETIREMENT		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED		DEPARTMENT
EMPLOYEE TERMINATION DATE		REASON						ID CARD FORMAT	MASK	

PART 2 DEPENDENT INFORMATION										
DEPENDENT INFORMATION (List persons to be covered/terminated.): ¹ Relationship Code (relationship to participant) SPO=Spouse SON=Son DAU=Daughter DEP=Other Dependent							² Benefit Type(s): M=Medical Rx=Prescription			
Add/ Drop	Last Name	First Name	MI	Social Security Number	Birth Date	Gender (Circle)	¹ Rel. Code	² Benefits (Circle - must match EE benefits)	Disabled Y N	
A D						M F		M/Rx	Y N	
A D						M F		M/Rx	Y N	
A D						M F		M/Rx	Y N	
A D						M F		M/Rx	Y N	
A D						M F		M/Rx	Y N	

IF ADDING OR DROPPING DEPENDENT, STATE REASON:

PART 3 OTHER INSURANCE INFORMATION										
ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached. <input type="checkbox"/>										
Name of other policy holder	Birth Date	Social Security Number	³ Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number or Medicare Number	⁴ Benefit Types	⁵ Policy Types	Coverage Date(s) Begin / / End / /	

PERSONS COVERED UNDER ABOVE POLICY:

³ Relationship Code (specify relation to participant): SPO=Spouse OTH=Other ⁴ Benefit Type(s): M=Medical Rx=Prescription ⁵ Policy Type(s): IND=Individual Policy GRP=Group Plan HMO=Health Maintenance Organization MED=Medicare

PART 4 COVERAGE DECLINATION	
To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;	
HEALTH PLAN COVERAGE (CHECK IF DECLINED)	REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)
I decline coverage for:	
<input type="checkbox"/> Myself <input type="checkbox"/> Children	<input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Medicare
<input type="checkbox"/> Spouse <input type="checkbox"/> Spouse and Children	<input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Other (explain) _____
I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily.	
If declining coverage for employee/dependent(s) please sign here.	Date

PART 5 DECLARATION	
<input type="checkbox"/> I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.	
Employee's Signature	Date