



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

**GROUP ENROLLMENT/CHANGE FORM
2023 - RETIRED
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 | | | | | | | | | | GENERAL 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 <input type="checkbox"/> Dental | | | |
| LAST NAME | | | FIRST NAME | | MI | SOCIAL SECURITY NO. | | | | EFFECTIVE DATE | | | |
| ADDRESS | | STREET | | CITY | | STATE | ZIP CODE | | HOME PHONE | | BIRTHDATE (mm/dd/yyyy) | E-MAIL ADDRESS | |
| HIRE DATE (mm/dd/yyyy) | | STATUS RETIRED | | DATE OF RETIREMENT (mm/dd/yyyy) | | GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED | <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | <input type="checkbox"/> SEPARATED | DEPARTMENT | | |
| TERMINATION DATE (mm/dd/yyyy) | | 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 D=Dental Rx=Prescription | | | |
| Add/Drop | Last Name | | First Name | | MI | Social Security Number | | | Birth Date (mm/dd/yyyy) | Gender (Circle) | ¹ Rel. Code | ² Benefits (Circle) | Disabled |
| A D | | | | | | | | | | M F | | M/Rx D | Y N |
| A D | | | | | | | | | | M F | | M/Rx D | Y N |
| A D | | | | | | | | | | M F | | M/Rx D | Y N |
| A D | | | | | | | | | | M F | | M/Rx D | Y N |
| A D | | | | | | | | | | M F | | M/Rx D | 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 D=Dental V=Vision 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"/> Spouse | <input type="checkbox"/> Spouse and Children | | <input type="checkbox"/> Covered by spouse's group coverage | | | <input type="checkbox"/> Spouse covered by employer's group medical coverage | | <input type="checkbox"/> Medicare | | <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 yourself/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 and authorize deductions from my earnings (if any) required to cover my share of the premium. | | | | | | | | | | | | | |
| Signature | | | | | | | | | | Date | | | |