



**ENROLLMENT/CHANGE FORM - RETIREE / COBRA / SURVIVING SPOUSE**

**NAME:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_  
**STREET:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
**CITY/STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **EFFECTIVE DATE:** \_\_\_\_\_  
**PHONE: WORK:** \_\_\_\_\_ **HOME:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_  
 (Female, Male, Undeclared)

Status		Activity Requested	Reason - Change in Family Status
<input type="checkbox"/> Retired MSRS <input type="checkbox"/> Retired Police Officer <input type="checkbox"/> Retired Fire Fighter, Paramedic, ERT <input type="checkbox"/> Retired Correctional Officer <input type="checkbox"/> Retired Deputy Sheriff	<input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Surviving Dependent <input type="checkbox"/> COBRA <input type="checkbox"/> Assessor <input type="checkbox"/> Judge <input type="checkbox"/> Other	<input type="checkbox"/> Enroll Self <input type="checkbox"/> Enroll Spouse <input type="checkbox"/> Enroll Dependent(s) <input type="checkbox"/> Reinstate Coverage <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent(s) <input type="checkbox"/> Switch to New Plan <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medicare <input type="checkbox"/> Retirement <input type="checkbox"/> Relocate In/Out of Area <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth of Child/Adoption or Permanent Legal Guardianship of Child <b>Date of Event:</b> _____

Attach documentation (i.e. Marriage License, Divorce Decree, etc.). Submit copy of Birth Certificate as soon as received.

Medical Coverage	Dental Coverage	Prescription	Vision		
<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<input type="checkbox"/> One Senior <input type="checkbox"/> Two Seniors <input type="checkbox"/> Individual plus Senior	<b>Base Plan</b> <input type="checkbox"/> Individual <input type="checkbox"/> Two - Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage	<b>Buy-Up Plan</b> <input type="checkbox"/> Individual <input type="checkbox"/> Two-Person <input type="checkbox"/> Family <input type="checkbox"/> No Coverage

<b>Name of Medical Plan:</b> _____  <input type="checkbox"/> HMO <input type="checkbox"/> PPO	<input type="checkbox"/> <b>Dental DMO</b> (Aetna Form must also be Completed for Dentist Selection).  <input type="checkbox"/> <b>Dental PPO</b>	<b>Other Health Coverage:</b> Must be completed if you or your dependents have other coverage.  <b>Name of Carrier:</b> _____  <b>Policy Number:</b> _____
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DEPENDENT	SS#	RELATION	SELECT COVERAGE				PRIMARY CARE PHYSICIAN	BIRTH DATE	SELECT ONE	
1.	_____	<u>Spouse</u>	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
2.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
3.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
4.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
5.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
6.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP
7.	_____	_____	<input type="checkbox"/> MED	<input type="checkbox"/> RX	<input type="checkbox"/> VIS	<input type="checkbox"/> DEN	_____	_____	<input type="checkbox"/> ADD	<input type="checkbox"/> DROP

**EXPLAIN BENEFIT CHANGES (if needed):** \_\_\_\_\_  
 If enrolled in Kaiser Medical HMO or the Dental DMO, you and your dependents must select a Center/Dentist. If you have any questions concerning your benefits and services either provided or excluded under your choice of health plan, please contact the Member Services Department of that health plan before signing this application below.

By signing this form, I understand that I cannot make changes during the plan year unless there is a family status change and I complete a benefits form **within 30 days** of the event. Rules for the plan changes will vary depending on my status. This form authorizes any licensed physician, hospital or health care provider to furnish my health plan with such medical information about myself and any eligible dependent as needed. I understand that my coverage and benefits may be adversely affected by my failure to provide complete and accurate information.

Signature \_\_\_\_\_

Date \_\_\_\_\_