



# Kern County Human Resources Health Benefits Change Form

This form is to be used by employees of the County of Kern who are eligible for the below medical, dental and vision coverage.

## 2019 Bi-weekly Premium contributions

	<b>Kern Legacy SHARE SELECT</b>		<b>Kern Legacy NETWORK PLUS</b>		<b>Kern Legacy MAX CHOICE</b>		<b>Kern Legacy CLASSIC CHOICE</b>		<b>KAISER Permanente</b>	
	Uses Kern Medical hospital and County-owned, Kern Health Care Network providers and contracted facilities.		Uses Kern Medical hospital and County-owned, Kern Health Care Network for both EPO and Plus tiers (includes Adventist Health Bakersfield).		Uses Anthem Blue Cross contracted providers and facilities.		Uses Anthem Blue Cross contracted providers and facilities.		Uses Kaiser Permanente contracted physicians and facilities including Adventist Health Bakersfield Medical Center.	
	DHMO Dental	PPO Dental	DHMO Dental	PPO Dental	DHMO Dental	PPO Dental	DHMO Dental	PPO Dental	DHMO Dental	PPO Dental
	Vision included		Vision included		Vision included		Vision included		Vision included	
	BI-WEEKLY PREMIUM		BI-WEEKLY PREMIUM		BI-WEEKLY PREMIUM		BI-WEEKLY PREMIUM		BI-WEEKLY PREMIUM	
Employee only	\$ 0	\$ 0	\$ 36	\$ 38	\$ 58	\$ 0	\$ 0	\$ 36	\$ 38	\$ 58
Employee + 1	\$ 11	\$ 14	\$ 69	\$ 72	\$104	\$ 11	\$ 14	\$ 69	\$ 72	\$104
Family (3 or more)	\$ 31	\$ 35	\$101	\$105	\$149	\$ 31	\$ 35	\$101	\$105	\$149

### IMPORTANT:

All required forms and documentation must be received by  
Kern County Human Resources -Health Benefits within 30 days of the permitting event,  
unless otherwise noted in the Health Benefits Eligibility Policy

Please return completed forms with supporting documentation (if applicable) to:

**Kern County Human Resources - Health Benefits**  
1115 Truxtun Avenue 1<sup>st</sup> Floor, Bakersfield, California 93301-4639

## REQUIRED DOCUMENTATION FOR DEPENDENTS' ENROLLMENT

### ALL ENROLLEES:

A Social Security Number must be furnished.

### FOR SPOUSE:

A copy of a marriage certificate must accompany the enrollment form.

### FOR DOMESTIC PARTNER:

A copy of a registration form filed with Secretary of State must accompany the enrollment form.

### FOR ALL CHILDREN:

A copy of a birth certificate must accompany the enrollment form **PLUS (if applicable):**

**For adopted children:** *Court documents* indicating final adoption. If the adoption is not final, court documents dated within the six months preceding an enrollment request indicating the adoption is pending. If neither of these documents is available, contact Kern County Human Resources – Health Benefits at (661) 868-3182.

**For foster children:** *Court documents* indicating current foster care placement.

**For guardianships:** *Court documents* indicating a guardianship has been established.

## DEPENDENTS' ELIGIBILITY SUMMARY

(SEE ELIGIBILITY POLICY FOR OFFICIAL ELIGIBILITY RULES)

### THE FOLLOWING DEPENDENTS ARE ELIGIBLE FOR COVERAGE

#### Spouse/Domestic Partner:

Employee's legal spouse or registered domestic partner

#### Natural or Step Child:

Child who is under the age of 26 OR

Unmarried child age 26 or older who is permanently disabled <sup>1</sup>

#### Adopted Child:

Employee's or employee's spouse's or domestic partner's legally adopted child under the age of 26; OR  
Employee's or employee's spouse's or domestic partner's unmarried legally adopted child age 26 or older who is permanently disabled <sup>1</sup>

#### Guardianships:

Unmarried child under the age of 26 for whom employee or spouse or domestic partner has legal guardianship, or had guardianship on the child's eighteenth birthday; OR

Unmarried child age 26 or older for whom employee or spouse or domestic partner has legal guardianship and who is permanently disabled <sup>1</sup>

<sup>1</sup> Dependents age 26 or older who have never been covered by the plan may ONLY be enrolled upon employee's initial enrollment. An employee's initial hire date is their initial opportunity to enroll. If not enrolled upon the initial opportunity to enroll, they cannot be enrolled subsequently if they are age 26 or older.

#### PLEASE NOTE:

- An incomplete form or failure to provide requested documentation will invalidate dependent's enrollment.
- A Contracted Primary Care Physician (PCP) must be used in order to receive In-Network benefits (EPO & Kern Legacy).
- Enrollment forms are subject to audit and additional documentation may be required.



# Kern County Human Resources Health Benefits Change Form

Effective Date : \_\_\_\_\_

Changes will be effective the 1<sup>st</sup> of the biweekly pay period following receipt in Health Benefits, unless otherwise noted in HB Eligibility Policy

Please Print Clearly:

EMPLOYEE'S LAST NAME	FIRST NAME	MIDDLE	EMPLOYEE ID OR SOCIAL SECURITY NUMBER
DAYTIME PHONE NUMBER	DEPARTMENT NAME	EMAIL ADDRESS	

## DEPENDENT(S) ENROLLMENT REQUEST:

REASON:  NEWBORN  MARRIAGE  DIVORCE  OTHER (Please indicate): \_\_\_\_\_

ACTION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER (M or F)	PRIMARY CARE PHYSICIAN (Network Plus & Share Select)
<input type="checkbox"/> ADD	Spouse/Dom. Partner					
<input type="checkbox"/> REMOVE	Spouse/Dom. Partner SSN					
<input type="checkbox"/> ADD	Child					
<input type="checkbox"/> REMOVE	Child SSN					
<input type="checkbox"/> ADD	Child					
<input type="checkbox"/> REMOVE	Child SSN					
<input type="checkbox"/> ADD	Child					
<input type="checkbox"/> REMOVE	Child SSN					
<input type="checkbox"/> ADD	Child					
<input type="checkbox"/> REMOVE	Child SSN					

## OTHER HEALTH INSURANCE INFORMATION:

- Is your spouse/domestic partner a Kern County employee?  YES  NO  
IF YES, provide his/her Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- Do you or any of your dependents have any other insurance or Medicare?  YES  NO  
IF YES, please provide the following information:

NAME OF SPOUSE/DOMESTIC PARTNER/ DEPENDENT (SUBSCRIBER)	EMPLOYER	INDIVIDUAL/FAMILY COVERAGE
NAME OF INSURANCE PLAN	CLAIMS ADDRESS	CUSTOMER SERVICE PHONE NUMBER

TO BE COMPLETED BY HEALTH BENEFITS:

DATE OF HIRE:	PLAN CODE:	EFFECTIVE DATE:

## EMPLOYEE CERTIFICATION

\_\_\_\_\_  
(initial)

I understand that any employee who obtains or continues coverage for any dependent who is not eligible for County-paid coverage, is subject to disciplinary action up to, and including, dismissal pursuant to Civil Service Rule 1700. Such employee shall also be liable to the County for the greater of (1) actual claims paid, and (2) other costs incurred by the County for coverage provided to the ineligible dependent.

\_\_\_\_\_  
(initial)

I have read and understand the eligibility policy and certify that dependents listed on this form are eligible for coverage.

\_\_\_\_\_  
(initial)

I understand that enrollment of dependents will not occur unless required documentation is submitted with this form. If I list dependents on this form but do not attach the required documentation, the dependent will not be enrolled.

\_\_\_\_\_  
(initial)

I understand that this form may be selected for audit. If this form is selected for audit, I will be required to provide further documentation to verify the accuracy of the statements made on this form.

\_\_\_\_\_  
(initial)

I understand that it is my responsibility to notify Kern County Human Resources-Health Benefits (not my departmental payroll clerk) of any changes in eligibility for any of my dependents.

\_\_\_\_\_  
(initial)

I understand that my completed Health Benefits Change Form and any required documents must be received by Kern County Human Resources-Health Benefits within 30 days of the permitting event (60 days for newborns) or my request will **NOT** be valid.

I have read and understand the foregoing statements and the Kern County Health Benefits Eligibility Policy. I certify **under penalty of perjury under the laws of the State of California** that all statements made on this form are true and correct.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### Need Additional Assistance?

Please contact us at (661) 868-3182

or

email us at [HealthBenefits@kerncounty.com](mailto:HealthBenefits@kerncounty.com)

### Please return completed forms to:

Kern County Human Resources - Health Benefits  
1115 Truxtun Avenue 1st Floor, Bakersfield, California 93301-4639