



Effective Date

Event Date

Reason

Plan No.

COBRA
VISION PLAN ENROLLMENT/CHANGE FORM

CHOOSE ONE: [] NEW COBRA ENROLLMENT [] OPEN ENROLLMENT [] CHANGE IN STATUS [] CANCEL COVERAGE

MAIN SUBSCRIBER INFORMATION

Check one [] MALE [] FEMALE Check one [] SINGLE [] MARRIED [] DOMESTIC PARTNER [] DIVORCED [] WIDOWED

Form fields for subscriber information: Empl. No., Social Security No., Last Name, First Name, MI, Date of Birth, Mailing Address, City, ST, ZIP, Phone, HOME, CELL, WORK, Email Address.

ENROLLEES - List ALL persons to be covered. Include yourself. You must also attach proof of dependent eligibility if enrolling dependents for the first time.

Table with 5 columns: Action, Name (Last Name, First Name), Social Security No., Date of Birth, Relationship. Includes rows for adding and removing dependents.

AGREEMENT - THIS SECTION MUST BE COMPLETED BY ALL SUBSCRIBERS

I certify that, to the best of my knowledge, all information furnished by me here is true and correct. I understand that I must submit a new Vision Plan Enrollment/Change form within 60 days of any change of status.

I certify that I have read and understand my and/or my dependents' COBRA Rights and Obligations enclosed in my COBRA Election Notice. I hereby elect to enroll in (or elect an authorized change to) the group vision plan maintained by San Bernardino County designated at the beginning of this form.

I acknowledge and understand that vision care providers may disclose health information about me or my dependents for purposes of treatment, payment, health care operations, and as permitted or required by law.

- By selecting this box, I authorize San Bernardino County to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment...
By selecting this box, I choose monthly COBRA payment coupons and opt out of automatic salary or monthly retirement benefit deductions.

Subscriber's Signature

Date

To authorize that your monthly COBRA payment be deducted from the monthly retirement benefit payment of your spouse, parent or state-registered domestic partner AND he or she is not enrolled in your COBRA plan, the section below must be completed by the parent, domestic partner, or spouse (the "Payee").

I, _____ (payee), authorize the San Bernardino County Employees' Retirement Association (SBCERA) to deduct from my monthly retirement benefit payment in the amount required to cover the COBRA monthly payment for my dependent, _____ (COBRA subscriber), including any future increases or decreases.

Subscriber's Signature _____ Date _____

For identification purposes, please provide one of the following: Payee Employee No. OR Last 4 digits of SSN: _____

San Bernardino County
Human Resources Department
Employee Benefits and Services Division - COBRA
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San Bernardino, CA 92415-0440
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