SUPERIOR COURT OF CALIFORNIA,
COUNTY OF KERN

GROUP ENROLLMENT/CHANGE FORM
2024

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

☐ New Enrollment ☐ Annual Enrollment
☐ Name/Address Change ☐ Change Enrollment
☐ Reinstatement ☐ Decline Coverage
☐ Rehire ☐ Termination

(Shaded area for office use only)

PART 1 EMPLOYEE INFORMATION

EMPLOYER SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN			**PLAN CHOICE** ☒PPO	**GROUP NUMBER** E-50	**Benefit Type(s):** ☐Medical/Rx ☐Dental/Vision
EMPLOYEE	**LAST**	**FIRST**	**MI**	**SOCIAL SECURITY NO.** - -	**EFFECTIVE DATE** MEDICAL / DENTAL
ADDRESS	**STREET**	**CITY**	**STATE** / **ZIP CODE**	**HOME PHONE** ( )	**BIRTHDATE** MO DAY YEAR
HIRE DATE	**STATUS** ☐ACTIVE ☐RETIRED	**IF RETIRED, DATE OF RETIREMENT**	**GENDER** ☐MALE ☐FEMALE	☐SINGLE ☐WIDOWED ☐SEPARATED ☐MARRIED ☐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 **D**=Dental **V**=Vision **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
A D						M F		☐Med/Rx ☐Den/Vis	Y N
A D						M F		☐Med/Rx ☐Den/Vis	Y N
A D						M F		☐Med/Rx ☐Den/Vis	Y N
A D						M F		☐Med/Rx ☐Den/Vis	Y N
A D						M F		☐Med/Rx ☐Den/Vis	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? ☐YES ☐NO **IF YES, PLEASE COMPLETE THIS SECTION.** **Check if additional form attached.** ☐

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)

I decline coverage for:

☐ Myself ☐ Children
☐ Spouse ☐ Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED)

☐ Covered by spouse's group coverage ☐ Medicare
☐ Spouse covered by employer's group medical coverage ☐ 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

☐ 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