SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

Print Form

FOR ADMINISTRATIVE USE ONLY
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

Empl. No.	Social Security No.	Last Name	First Name	MI	Date of Birth	For name change, list former name here

Mailing Address ☐ Check here if new 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.

Action	Name (Last Name, First Name)	Social Security No.	Date of Birth	Relationship
☐Add ☐Remove				Self
☐Add ☐Remove				
☐Add ☐Remove				
☐Add ☐Remove				
☐Add ☐Remove				
☐Add ☐Remove				
☐Add ☐Remove				
☐Add ☐Remove				

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 the County of San Bernardino designated at the beginning of this form. I have also designated in the ENROLLEES section myself and/or my eligible dependents who are to be enrolled into the vision plan. I agree to be responsible for the full applicable premium payment for the coverage selected, which will include a 2% administration charge. I understand that failure to pay premiums timely will result in the termination of coverage and that my and my dependents' COBRA rights will be forfeited.

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. The vision insurance carrier's Notice of Privacy Practices can be obtained at its website or by calling member services.

If applicable: I authorize the County of San Bernardino to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment (including any future premium increases or decreases).

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:* _____

County of San Bernardino
Human Resources Department
Employee Benefits and Services Division - COBRA
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DISTRIBUTION: HR - EBSD (0440)