



COBRA Vision Plan Enrollment/Change Form

FOR ADMINISTRATIVE USE ONLY			
Effective Date	Month	Day	Year
Event Date			
Reason			
Group Number			

CHOOSE ONE OPEN ENROLLMENT NEW COBRA ENROLLMENT CHANGE IN STATUS CANCEL COVERAGE

MAIN SUBSCRIBER INFORMATION

EMPLOYEE NO.	SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MI
CHECK ONE <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	CHECK ONE <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
MAILING ADDRESS		CHECK HERE IF NEW ADDRESS <input type="checkbox"/>	HOME PHONE ()	ALTERNATE PHONE ()
CITY		STATE	ZIP CODE	FOR NAME CHANGES, LIST FORMER NAME HERE

List **ALL** persons to be covered **Please list yourself for coverage.**
(If applicable, you must attach proof of dependent eligibility if enrolling dependents.)

Action	Last Name	First Name	Social Security #	Date of Birth	Relationship
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> Remove					
<input type="checkbox"/> Add <input type="checkbox"/> 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 health and welfare plan maintained by the County of San Bernardino designated in Section B. I have also designated in Section D, myself and/or eligible dependents that are enrolled in 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 dependents' COBRA rights will be forfeited as a result of failure to pay premiums timely.

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 Signature _____

Subscriber Print Name _____ Date _____