

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

PREMIUM DEDUCTION ELECTION

Must print in Blac									
Employee	ID Rcd N	О.		Last Na	ame, First Nar	ne			
Departm			rtment		Department ID			Telephone	
			REASON FOR	ELECTION	AGREEME	NT			
Date		Even	nt	Date	Event				
	☐ New Hire				☐ Moved in/out of the HMO area				
	☐ Adoption/	Guardianship	*		☐ Needles Subsidy/Change in Subsidy Eligibility				
	☐ Birth*				☐ Open Enrollment				
	☐ Death*	O&D from Employe	ee + Spouse to Employee Only		Reduction in Hours for Employee or Spouse/Domestic Partner*				
	Disabled	Over-Age De vide required D			Return from Unpaid Leave of Absence				
	(Please prov		Domestic Partnership* ailing address of ')		Unpaid Leave of Absence Taken by Employee or Spouse/Domestic Partner*				
	Mailing Addre	ess:							
	City, State, Z	ip:							
		s Spouse's/Do ent or Other C		Other:					
☐ Marriage/Domestic Part			rtnership*						
Orders, Final D	ivorce Decree	, Benefit Conf	ropriate tax elections a	OBRA Notice, L FIT ELECT and list all deper	oss of Coverage	e Lette	n, and T	ermination N	c Partner/
Plan	Tax	Tax	Name	ne of Dependent		Yes	No	Ch Before Tax	
Medical									
Dental									
Voluntary Life									
AD&D									
Vision*									
*Tax election for vision coverage applies only to Firefighters, Nurses, Probation,									
Specialized Peace Officer - Supervisory									
units									
				HR Use Only nments Vision ☐ Life					
DISTRIBUTION:	Original - EBSD		Reviewed By (Employee ID)	D	ate	Keyed By (Employee ID)	Date		

Authorization and Certification

Employee signature is required for all qualifying events

I understand my share of the plan coverage cost may be adjusted to reflect any rate change. I acknowledge that my election is irrevocable unless there is a qualifying event in my family status and that in the absence of a family status change, my next opportunity to change this election will be during Open Enrollment. If I do not complete and return a new election form during Open Enrollment, the elections specified on page one of this Premium Deduction Election form will be maintained for the new plan year. I hereby authorize the County of San Bernardino to obtain eligibility dates of coverage from previous Medical Plans for the exclusive purpose of determining my eligibility for the County of San Bernardino's Premium Conversion Benefit Plan as required under Internal Revenue Code Section 125. I understand this authorization is only in effect for 60 days from the date of my signature. Needles Subsidy Eligible Employees: I understand that my eligibility for the "Needles Subsidy" is entirely contingent upon being assigned to Needles, Trona, or Baker as my work location. I understand that it is my responsibility to notify the Employee Benefits and Services Division (EBSD) should my assigned work location change to an area other than Needles. Trona, or Baker. I further understand that should it be discovered that the Needles Subsidy has been paid to me in error, that the County will collect, through payroll deduction, any amount of subsidy for which I received and was not eligible. Signature of Employee Print Employee Name Date I understand my options in the Benefit Plan. I understand the County will reduce my salary in the amount of the plan coverage cost on either a before tax or after tax basis. I understand that if at any time my or my family's eligibility changes, I will notify EBSD or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit deductions. For example, if I get divorced I am required to remove my ex-spouse from County sponsored Benefit Plans. I understand that I will be taxed on the fair market value of any benefits for any individual who is not my Federal/State tax dependent. **Employee Signature** Date Payroll Specialist (Print & Sign) Telephone Date Office Use Only **Authorized Representative Signature** Date ☐ Approved □ Denied

REV. 8/09/2016 2 of 2 (Premium Deduction Election)