City of San Luis Benefit Enrollment Form

Employee Effective Date: _____
Dependent Effective Date: _____
☐ New Hire (Date) _____
☐ Open Enrollment (Date) _____

☐ Add/Remove Dependent (Indicate QLE):

Birth: _____ Adoption: _____
Marriage: _____ Divorce: _____
Loss of Coverage: _____ Other: _____

Social Security No. ☐☐☐ ☐☐ ☐☐☐☐

Last Name _____ First Name _____ M.I. _____

DOB _____ Gender _____

Mailing Address _____ Physical Address _____

City _____ State _____ Zip Code _____

Personal Email _____

Coverage Selected

☐ **US/MEXICO Medical**
☐ **MEXICO Medical**
- ☐ Employee Only
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)
- ☐ Family

☐ **US/MEXICO Dental**
☐ **MEXICO Dental**
- ☐ Employee Only
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)
- ☐ Family

☐ **Vision**
- ☐ Employee Only
- ☐ Employee and Spouse
- ☐ Employee and Child(ren)
- ☐ Family

☐ **HealthiestYou**
- ☐ Employee Only
- ☐ Family

☐ Decline Medical Coverage
☐ Decline Dental Coverage
☐ Decline Vision Coverage
☐ Decline HY Coverage

Dependent Information

Add	Change	Delete	Last Name, First Name, M.I.	Social Security	Relationship	Gender	DOB
☐							

Dual Coverage/Other Coverage

Is there any other Group Insurance for your family members? ☐ Yes ☐ No (Please provide copy of insurance card.)

If yes, name of Policyholder _____ Policyholder's DOB _____

Please list dependents under this policy _____

Name of Insurance Company _____ Plan/Policy # _____

Waiver Of Coverage

After a thorough explanation of the health plan and after careful consideration, I am waving ALL benefit coverage for:

☐ Employee ☐ Spouse ☐ Children

Reason _____

Disclaimer: I understand that this waiver of coverage: is effective as of date indicated below and that I may be able to re-enroll in the group health plan at a later date, subject to the terms and conditions of the plan, and any applicable eligibility requirements.

Authorization

AUTHORIZATION TO RELEASE INFORMATION: On behalf of myself and any enrolled dependent, I authorize any health care professional or entity to give vendors associated with this plan, any and all records or information pertaining to medical history or services rendered for administrative purposes, including evaluation of an application or a claim, and for any analytical or research purposes.

AUTHORIZATION FOR PAYROLL DEDUCTION: I hereby authorize my Employer to deduct any health insurance premium that may be due from my paycheck.

_____ Employee Signature

_____ Date