SDRMA/ CSAC EIA Health
Small Group Benefit Election Form

Group Name: Alpine County

County: Alpine

Effective Date: _____

MEMBER ENROLLMENT OR CHANGE – COMPLETE IN FULL					
Name (Last, First, MI):		Social Security #:		Birth Date (mm/dd/yy):	☐ Male ☐ Female
Home Street Address: (No P.O. Box) City State Zip				Home Phone:	Work Phone:
Mailing Address: (P.O. Box may be used) City State Zip ☐ Same as Home Address				E-mail Address:	
Occupation/Title:	Date of Hire (mm/dd/yy):	Employee Status: ☐ Full Time ☐ Early Retiree ☐ Part Time ☐ Medicare Retiree			
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced					

TYPE OF ACTION

- ☐ New Hire Enrollment (list below all dependents to be covered)
- ☐ Annual Open Enrollment
- ☐ Add or Drop Dependent due to Qualifying Event: QE Event: _____
- ☐ Termination
- ☐ Other: _____
- ☐ Name/Address Change

MEMBER ELECTION

Blue Shield Access + HMO 15 ☐ EE Only ☐ EE + 1 ☐ EE + Family Employee PCP Code: _____ Provider Name:_____ Existing Patient: Yes / No	**Blue Shield Access + HMO 20** ☐ EE Only ☐ EE + 1 ☐ EE + Family Employee PCP Code: _____ Provider Name:_____ Existing Patient: Yes / No	**Blue Shield EPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family
Blue Shield Platinum PPO ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield Silver PPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield Gold PPO** ☐ EE Only ☐ EE + 1 ☐ EE + Family
Blue Shield HDHP 10% ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Blue Shield HDHP 20%** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**HSA (for HDHP Elections Only):** ☐ Yes ☐ No

SDRMA

DEPENDENT COVERAGE

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
HMO Provider Name (HMO Plans only): Existing Patient: Yes / No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO Plans only): Existing Patient: Yes / No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO Plans only): Existing Patient: Yes / No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO Plans only): Existing Patient: Yes / No			PCP Code:	

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child
HMO Provider Name (HMO Plans only): Existing Patient: Yes / No			PCP Code:	

PLEASE READ THE FOLLOWING- AUTHORIZATION REQUIRED	
I declare that the information given on this form is true and complete to the best of my knowledge and belief. I understand that the information I have provided is the basis on which coverage may be issued under these plans. Any misstatements or omissions may result in future claims being denied and/or my coverage(s) being rescinded. I know that if I do not enroll within 30 days of becoming first eligible (or within 31 days of an IRS-qualified change in status) I will have to wait until the next annual enrollment, and may be required to submit evidence of insurability for certain coverage. **My signature below certifies that I have applied for the benefits indicated on this form. I understand that my benefit elections may result in deductions from my pay and authorize my employer to make the required deduction.** **By signing below, I acknowledge all of the terms and provisions as described above.**	
Signature:	Date:

DECLINATION OF COVERAGE – SIGNATURE REQUIRED- Complete only if declining medical coverage	
I understand that I am eligible for medical coverage through my employer. I waive the right to enroll in the medical plan as offered by my employer for the following persons (please check all that apply below): ☐ Self ☐ Spouse ☐ Child(ren) **Reason for waiver:** ☐ I have my own other group coverage ☐ We are covered through my spouse's employer ☐ My spouse and dependents have other group coverage **I understand and agree by signing this document that I am declining coverage and if I fail to show proof of other group coverage that I will be added to the lowest cost plan automatically. I understand by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other coverage). If a HIPPA qualifying event occurs and I want to enroll in other group coverage I know that I must submit proof of other group coverage or my request will not be processed.**	
Signature:	Date: