MONTEREY PENINSULA College

Trustmark benefits beyond benefits

GROUP ENROLLMENT / CHANGE FORM

print clearly using a ballpoint pen
Complete applicable information only

FOR OFFICE USE ONLY:

Effective Date _____

PART 1

☐ New Enrollment ☐ Open Enrollment ☐ Name / Address Change ☐ Termination ☐ Waive Coverage ☐ Other Coverage: _____

☐ Add Dependent(s) –

☐ Domestic Partner – Date of Registration:____/____/____ ☐ Spouse – Date of Marriage:____/____/____ ☐ Child – Reason:_____

☐ Remove Dependent(s) – Reason:_____

PART 2 EMPLOYEE INFORMATION

EMPLOYEE **LAST** **FIRST** **MI**

SOCIAL SECURITY NUMBER	GENDER	BIRTH DATE:	HOME PHONE	MARITAL STATUS:
	☐ MALE ☐ FEMALE	/ /	( )	□ SINGLE □ MARRIED □ SEPARATED □ DIVORCED

ADDRESS **STREET** **CITY** **STATE** **ZIP CODE**

DATE OF HIRE	CLASSIFICATION	COVERAGE ELECTION		
		☐ MEDICAL/DRUG	☐ DENTAL (Base Plan)	☐ VISION – Emp. Only (Base Plan)
			☐ DENTAL (Buy-Up Plan)	☐ VISION – Emp. & Fam. (Buy-Up Plan)

PART 3 DEPENDENT INFORMATION

Complete the information below. Check the disabled box only if the condition prohibits the dependent from working or performing daily activities. Please indicate if the dependent is covered by a health insurance plan by checking the Other Health Coverage box then complete the Prior Coverage section below.

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Relation	Last Name	First Name (Legal Name)	MI	Social Security Number	Date of Birth	Gender (Circle)	Disabled (Circle)
☐ Spouse ☐ Domestic Partner						M F	Y N
Child						M F	Y N
Child						M F	Y N
Child						M F	Y N
Child						M F	Y N
Child						M F	Y N
Child						M F	Y N

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PART 4 WAIVE COVERAGE

To be completed if any coverage is declined or refused by an eligible employee and/or their eligible family members:

HEALTH PLAN COVERAGE (CHECK IF DECLINE)

I decline coverage for:

☐ Myself ☐ Children ☐ Spouse ☐ Spouse and Children

REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINE)

☐ Covered by spouse's group coverage ☐ Medicare

☐ Spouse covered by employer's group medical coverage ☐ Other (explain)_____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and / or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. I also realize I will NOT be able to enroll until the next open enrollment period or have a qualifying event.

_____ _____

If declining coverage for employee and/or dependent(s) please sign here — Date

PART 5 OTHER COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete this section to receive credit for that coverage.

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Signature	**Date**
X	

PART 6 EMPLOYEE AGREEMENT

I elect coverage as indicated on this form and consent to all terms and conditions stated herein. Furthermore, I declare that the information represented above is true and correct. If contributions are required for health care plan coverage, I authorize my employer to deduct such contributions from earnings via payroll deduction until future notice. My participation in the plan is subject to all the plan terms and conditions as set forth in the plan documents and Summary Plan Description. **1.** I authorize any payroll deductions required for the elections I have made above. **2.** I understand that I cannot change my elections until the next open enrollment period, but I may change coverage for the dependents I am insuring or add new dependents if there is a "qualified" change in status.

Signature	**Date**
X	