MPC MONTEREY PENINSULA COLLEGE

DELTA HEALTH SYSTEMS

# GROUP ENROLLMENT / CHANGE FORM

**Please 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

☐ 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 ☐ MALE ☐ FEMALE | BIRTH DATE: / / | HOME PHONE ( ) | MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED |
|---|---|---|---|---|

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

| DATE OF HIRE | CLASSIFICATION | COVERAGE ELECTION ☐ MEDICAL/DRUG ☐ DENTAL ☐ VISION (Employee only) |
|---|---|---|

## 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.**
**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 | Birth Date | Gender (Circle) | Disabled |
|---|---|---|---|---|---|---|---|
| ☐ Spouse<br>☐ 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 |

## 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 / dependent(s) please sign here** **Date**

| Signature<br>X | Date |
|---|---|