YOLO COUNTY BENEFIT ACTION FORM

CalPERS Health Benefits Program ~ Delta Dental of California ~ Medical Eye Services of California

☐ CalPERS Health Insurance Plan _____ ☐ DELTA DENTAL (Group # 3559-0001) ☐ MES (Group #15174)
CalPERS Region ☐ Yolo/Sac ☐ Bay Area ☐ DELTA Buy Up (Group # 3559-1001) ☐ MES Buy Up (Group #24889)

EMPLOYEE DATA

LAST NAME	FIRST NAME	MIDDLE	DEPT	EMPLOYEE ID	BARGAINING UNIT

SOCIAL SECURITY #	DATE OF BIRTH	SEX ☐ Male ☐ Female	MARITAL STATUS ☐ Single ☐ Married	DAYTIME PHONE NUMBER

MAILING ADDRESS	ALTERNATE ZIP CODE (HEALTH ONLY)
	PRIMARY CARE PHYSICIAN (HMO'S ONLY, EXCEPT KAISER):

BENEFIT ACTION

☐ NEW ENROLLMENT ☐ CHANGE TO ENROLLMENT ☐ CANCELLATION OR TERMINATION ☐ LEAVE OF ABSENCE

REASON FOR ACTION:	PERMITTING EVENT DATE:	EFFECTIVE DATE OF ACTION:

DEPENDENT INFORMATION

Last, First, Middle	H	D	V	Add/ Del	Sex M F	Birthdate MM/DD/YY	SS# (required)	Relationship to Employee	Primary Care Physician (HMO'S Only)

HR/PR ONLY

DENTAL AND VISION (to be completed by HR)		**HEALTH (to be completed by HR)**	
DEDUCTION EFFECTIVE DATE:	COVERAGE EFFECTIVE DATE:	DEDUCTION EFFECTIVE DATE:	COVERAGE EFFECTIVE DATE:
DENTAL LEVEL OF COVERAGE: ☐ Emp ☐ Emp & 1 ☐ Emp & 2	VISION LEVEL OF COVERAGE: ☐ Emp ☐ Emp & 1 ☐ Emp & 2	HEALTH LEVEL OF COVERAGE: ☐ Emp ☐ Emp & 1 ☐ Emp & 2	☐ Marriage Cert. ☐ Birth Cert. ☐ Dom. Partner Registration ☐ Affidaviit for Econ. Dep. Children

I authorize deductions to be made from my salary to cover my share of the cost of enrollment into the Yolo County employee benefits programs. I certify that the names of all dependents listed above are eligible family members as defined by the program eligibility rules.

ENROLLEE SIGNATURE _____ DATE _____ HR APPROVAL _____

Rev. May 2016