☐ New Enrollment ☐ Open Enrollment

TEHAMA COUNTY HEALTH INSURANCE ENROLLMENT FORM

EMPLOYEE NAME:	**EMPLOYEE SSN#:**	**HIRE DATE:**	**DOB:**
ADDRESS:	**CITY, STATE, ZIP:**		
PLAN CHOICE: _____ EPO _____ PPO (Includes prescription, dental, vision and life)	**MARITAL STATUS: ____ SINGLE _____ MARRIED _____ REGISTERED DOMESTIC PARTNERSHIP**		
DEPARTMENT:	**BARGAINING UNIT OR JOB TITLE:**		
I WANT MY PREMIUMS TO BE DEDUCTED FROM MY PAYCHECK _____ PRE-TAX, OR ____ AFTER TAXES ARE DEDUCTED.			

PLEASE LIST BELOW ALL FAMILY MEMBERS THAT YOU WANT TO ENROLL IN YOUR INSURANCE PLAN.
WHEN ENROLLING A SPOUSE OR DOMESTIC PARTNER YOU ARE REQUIRED TO PROVIDE A MARRIAGE LICENSE OR REGISTERED DOMESTIC PARTNERSHIP CERTIFICATE.

SEX	LAST NAME	FIRST NAME	DOB	AGE	RELATIONSHIP TO YOU	SSN#	DOES THIS DEPENDENT HAVE OTHER COVERAGE AVAILABLE? PLEASE EXPLAIN.

My signature below indicates that all information that I provided above is true and accurate to the best of my knowledge and that I authorize the Payroll Department to deduct my premiums from my paychecks. This enrollment form is for the bundled health insurance plan which includes health, prescription, dental, vision and life.

_____ Signature of Employee

_____ Date

Payroll Use Only