



# TEHAMA COUNTY HEALTH INSURANCE CHANGE FORM

**TYPE OF CHANGE:**  Dependent Status  Drop Coverage  Pre-tax or Post tax Premiums  Plan Change

Employee's Name: _____	<input type="checkbox"/> Deduct premiums <b>pre-tax</b> <input type="checkbox"/> Deduct premiums <b>after taxes</b>
<b>CHANGE OF DEPENDENT STATUS</b> (Please list name of dependent below)	
<input type="checkbox"/> Add Spouse – Date of Marriage ___/___/___	<input type="checkbox"/> Delete Spouse – Effective Date ___/___/___
<input type="checkbox"/> Add Registered Domestic Partner – Effective date ___/___/___	<input type="checkbox"/> Delete Registered Domestic Partner – Effective Date ___/___/___
<input type="checkbox"/> Add Child – Effective date    /    /    Reason: _____	<input type="checkbox"/> Delete Child – Effective Date    /    /    Reason: _____
<b>PLAN CHANGE</b>	
You must have a qualified status change to change plans outside of the open enrollment period. A qualified status change is marriage, divorce, birth of a child, loss of spouse's insurance coverage, etc. Please call the Personnel Office if you have a question about your status change.	
<b>CHANGE PLAN TO:</b> <input type="checkbox"/> EPO <input type="checkbox"/> PPO	
PLEASE EXPLAIN YOUR STATUS CHANGE: _____	

**PLEASE LIST ALL DEPENDENTS BELOW THAT YOU ARE ADDING OR DELETING.**

WHEN ENROLLING A SPOUSE OR DOMESTIC PARTNER YOU ARE REQUIRED TO PROVIDE A MARRIAGE LICENSE OR REGISTERED DOMESTIC PARTNERSHIP CERTIFICATE.

ADD OR DELETE?	DEPENDENT'S NAME (Last, First, M.I.)	SEX	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 form is for the bundled health insurance plan which includes health, prescription, dental, vision and life.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

Payroll Use Only