MEDICAL ENROLLMENT/CHANGE FORM

cis benefits
www.cisbenefits.org

Check all that apply:

☐ New enrollment* (*new hire, newly eligible*)
☐ New enrollment due to loss of other group coverage

☐ Open enrollment plan change.
☐ Open enrollment* covered dependent(s): ☐ *Adding* ☐ *Dropping*

☐ Mid-year change effective as of _____________ due to the following event:
☐ *Marriage* ☐ *Birth* ☐ *Divorce* ☐ *Death* ☐ *Other:* ____

EMPLOYEE INFORMATION

EMPLOYEE'S FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	BIRTHDATE (MM/DD/YY)

ADDRESS	CITY	ST	ZIP

PHONE	ALTERNATE PHONE (optional)	GENDER ☐ M ☐ F

EMPLOYEE'S JOB TITLE	DATE OF HIRE

MEDICAL PLAN SELECTION

☐ HDHP-4 with VSP-A and Health Savings Account ☐ PPO Copay Plan H with optional Flexible Spending Account

DEPENDENT INFORMATION

NAME	MI	LAST	RELATIONSHIP	SOCIAL SECURITY NO.	BIRTHDATE	GENDER
SPOUSE'S FIRST NAME *	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
DOMESTIC PARTNER'S FIRST NAME **	MI	LAST		SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
CHILD'S FIRST NAME*	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
CHILD'S FIRST NAME*	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
CHILD'S FIRST NAME*	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
CHILD'S FIRST NAME*	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F
CHILD'S FIRST NAME*	MI	LAST	RELATIONSHIP ☐ NATURAL ☐ STEP ☐ LEGAL GUARDIAN	SOCIAL SECURITY NO.	BIRTHDATE	GENDER ☐ M ☐ F

**** Proof of dependent is required by CIS and must be uploaded to CIS-CONNECT within 60 days of enrollment.***
***** Requires Certificate of Domestic Partnership.***

ACKNOWLEDGMENT

I wish to participate in the plan selected above. I authorize deductions from my wages to cover my contribution toward the cost of coverage. I understand that my premium share will change when/if the plan cost is updated by the carrier or should my regular work hours be reduced (premium share is subject to prorating based on FTE). I further acknowledge that qualifying events must be reported to Clatsop County *and* City County Insurance Services (CIS) should I wish to make changes to my coverage.

Signature: ____ Date: _________________