County of San Mateo
Employee Benefits Enrollment/Waiver Form
(Affordable Care Act (ACA))

SECTION 1: Employee Information					
Name (Last, First, Middle):		Social Security Number:	Date of Birth:	Hire Date:	Work Email:
Home Address (Nubmer, Street, Apt #)	City	State	Zip Code	Phone Number:	Alternate Email:
Gender: ( ) M ( ) F	Marital Status: ( )Single ( ) Married ( )Separated ( )Divorced ( ) Domestic Partner				

Section 2: Coverage Election						
Medical:	( ) Kaiser HDHP	( )Employee Only	( ) Employee +1	( ) Family Coverage		
Health Savings Account: (H.S.A)	( ) Wells Fargo	Employee Annual Contribution election (OPTIONAL):	$ _____	***note: you have to be enrolled in the HDHP to qualify for the H.S.A. If you enroll in the Kasier HDHP, you will be automatically enrolled in the Wells Fargo H.S.A. to receive the employer contribution.**		

Section 3: Dependent Information

Relationship	Proof of Eligibility included with this form	Last Name	First Name, Middle Name	Social Security No	Date of Birth	Gender (M/F)	Totally Disabled (Y/N)
					/ /		

Have you included tax-qualified dependents? ( )Yes ( ) No If "yes" idicate name/s:_____

Do the tax qualified dependents reside with you? ( ) Yes ( ) N Are they depedent upon you for support and maintenance? ( ) Yes ( ) No

Section 4: Signature for Enrollment in Coverage

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deducution contribution is shown on a schedule that has been provided to me and that the amount may change in the future. I understandt that any premiums I am obligated to pay for heath care coverage for myself and/or my dependents will be deducted from my pay on a pre-tax basis. This signature also verifies the accuracy of the information on this form.

Employee's Signature to enroll: _____ Date: _____

Section 5: Declination of Coverage

Insurance plan you are choosing to waive: ( ) Medical- Kaiser High Deductible Health Plan

I understand that I was offered the opportunity to enroll in affordable, comprehensive health insurance coverage through my employment with the County of San Mateo. I understand that as of January 1, 2014, I am required by law to maintain an acceptable level of health insurance coverage for myself and my dependents.

Further, I understand unless I experience a qualifying event as defined by the IRS, I will not be allowed to enroll in coverage or make changes to my selection until the next open enrollment period.

Employee's Signature for DECLINATION of Coverage: _____ Date: _____

ENROLLMENT/WAIVER FORM SUBMISSION INSTRUCTIONS

1.) submit Form and Proof of Eligibilty Documentation (if adding dependents) to the Benefits Division on or before March 4th by either:
a.) Email at benefits@smcgov.org
b.) Fax at (650)599-1573
c.) Pony mail to HRD-133
d.) Mail to 455 County Center 5th Floor HRD133 Redwood City, CA 94063 Attention: Benefits Division