COUNTY OF SAN MATEO
HUMAN RESOURCES DEPARTMENT
EMPLOYEE BENEFITS DIVISION

PHONE: (650) 363-1919
FAX: (650) 599-1573
EMAIL: Benefits@smcgov.org

RETIREE OPEN ENROLLMENT CHANGE FORM – VOLUNTARY PLANS

YOU DO NOT NEED TO COMPLETE AND RETURN THIS FORM IF YOU ARE NOT MAKING ANY CHANGES TO YOUR EXISTING BENEFIT ELECTIONS.

IF MAKING CHANGES RETURN FORM BY NOVEMBER 10, 2022 | ALL CHANGES EFFECTIVE JANUARY 1, 2023

Fax: 650-599-1573 | E-Mail: benefits@smcgov.org

IF MAKING CHANGES, SUBMIT BY FAX OR EMAIL. SENDING VIA USPS MAIL MAY CREATE ENROLLMENT DELAYS.

1. RETIREE'S CURRENT INFORMATION - REQUIRED

LAST NAME | **FIRST NAME** | **MIDDLE INITIAL**

SOCIAL SECURITY # | **DATE OF BIRTH** | **GENDER**

CELLPHONE NUMBER | **HOME NUMBER** | **EMAIL ADDRESS**

☐ **CHECK BOX IF ADDRESS HAS CHANGED**

Permanent Address

STREET ADDRESS **NO P.O. BOXES**

CITY | **STATE** | **ZIP**

2. ENROLL IN THE VOLUNTARY DENTAL/VISION PLAN(S) EFFECTIVE JANUARY 1, 2023

- **Enrollment in one of the voluntary plans requires a 12-month enrollment period.**
- **County of San Mateo Retirees who terminated their employment with the County and chose to defer their pension benefits to a later date (Deferred Retirement) are not eligible to enroll in any of the County's retiree health plans including voluntary dental and vision coverage**

VISION PLAN

Action	Provider/Plan	Coverage			
☐ ENROLL	Voluntary Vision Service	☐ Retiree Only	☐ Retiree + Spouse/Domestic Partner	☐ Retiree + Child	☐ Family

DENTAL PLAN

Action	Provider/Plan	Coverage			
☐ ENROLL	Voluntary Cigna DHMO	☐ Retiree Only	☐ Retiree + Spouse/Domestic Partner	☐ Retiree + Child	☐ Family
☐ ENROLL	Voluntary Cigna DPPO	☐ Retiree Only	☐ Retiree + Spouse/Domestic Partner	☐ Retiree + Child	☐ Family

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3. ADD DEPENDENT(S) (complete if you want to add coverage for dependent(s))

☐ Dependent #1	LAST NAME _____ FIRST NAME _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____	**Gender:** ☐ Male ☐ Female **Benefits:** ☐ Dental ☐ Vision **Relationship:** ☐ Spouse ☐ Domestic Partner ☐ Child
☐ Dependent #2	LAST NAME _____ FIRST NAME _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____	**Gender:** ☐ Male ☐ Female **Benefits:** ☐ Dental ☐ Vision **Relationship:** ☐ Child
☐ Dependent #3	LAST NAME _____ FIRST NAME _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____	**Gender:** ☐ Male ☐ Female **Benefits:** ☐ Dental ☐ Vision **Relationship:** ☐ Child

4. FOR RETIREES WHO MADE OPEN ENROLLEMENT CHANGES - REQUIRED SIGNATURE

FINAL SIGNATURE

SIGNATURE & ACKNOWLEDGEMENT REQUIRED

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ **I have read, understand, and agree to the terms and condition above.**

Retiree Signature _____ **Date** _____

COMMENTS OR SPECIAL INSTRUCTIONS

QUESTIONS?

Visit our website for detailed plan information and rates!

https://www.smcgov.org/hr/retiree-benefits

FOR HR USE ONLY:
Date Entered in BCC: _____ Date OE Change Confirmation mailed: _____ HR Partner: _____

HR BENEFITS USE ONLY	
Effective Date:	
REASON FOR EFT:	
☐ New Retiree	☐ Medical
☐ COBRA Expiration	☐ Dental
☐ Sick Leave Expiration	☐ Vision

bcc
administrative solutions that work

INDIVIDUAL ELECTRONIC FUNDS TRANSFER (EFT)

Group Name: County of San Mateo **Customer Number:** CSM

Customer Name: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

☐ Select this box to authorize an ***Invoice/Premium EFT Payment***

Name of Financial Institution: _____

Bank Routing Number: _____ Account Number: _____

Account Name: _____ ☐ Checking Account ☐ Savings Account

If Electronic Debit Authorization (EDA) is required, instruct financial institution to set the authorization as:

Bank Filter

Submitting Bank (ODFI): **Dollar Bank**

Company Name (Acct Name): **Benefit Coordinators Corp.**

Contract Number: **2251453488**

Attach Check

--- Attach Check Here ---

Please attach a voided check and return this form to:
San Mateo County, Benefits Department
455 County Center, 5th Floor
Redwood City, CA 94063

TERMS: This authority is to remain in full force and effect in conjunction with the Agreement until BCC and the financial institution have received written notification of its termination in such time and in such manner as to afford BCC and the financial institution a reasonable time to act accordingly. In the event that my electronic debit or transfer is returned, I agree that a $25 returned-item fee will be charged automatically to my account.

Signature _____ Date _____

Print Name _____ Phone Number _____

Rev 10.2016