



Revision Date 03/18/24

<b>Group Name</b> <div style="text-align: center; font-size: 1.2em;">County Of Humboldt</div>	<b>Group Number: PDV 00159</b>
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**A ENROLLEE (Complete this section for new enrollment or change of status)**

<b>Name</b>			<b>Social Security Number</b>		<b>Date Employed</b>		
Last	First	Middle Initial			Month	Day	Year
<b>Birthdate</b> Month / Day / Year			<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married		<b>Do you have Dependent children?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Executed by:</b> _____							
<input type="checkbox"/> BCC				<input type="checkbox"/> COBRA			
Mailing Address _____					Telephone Number (   ) _____		
City _____		State _____		Zip Code _____			

**Please Note: The first day that you are covered will be the first of the month following the submission of a complete dental enrollment form. You are eligible for dental the first of the month following your hire date. Dependent children are eligible for county dental coverage up to the age of "26" and can be enrolled without requirements; they do not have to be a student, live in your household, or be single.**

**B Change to Existing Enrollment**

Reason for Change - _____	<b>NOTE: Effective Date is for Benefit Officer to Enter. Please Leave Blank.</b> Effective Date of Change ____ / ____ / ____
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**C DEPENDENTS (Complete for new enrollment or to add or delete dependents)**

Spouse Last Name	First	M.I.	Add/Delete	Sex - M/F	D.O.B.	Marriage/Divorce Date	Spouse's Social Security #
Child Last Name	First	M.I.	Add/Delete	Sex - M/F	D.O.B.	If Child is 26 years or older and disabled:	Child's Social Security #
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	

**D Signature (Form must be signed to be processed)**

I understand there is no contribution required by me for coverage of myself or my dependents (Exception- See COBRA enrollment). I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature	Date
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\*\*Please submit completed form to Risk Management at [riskmgmt@co.humboldt.ca.us](mailto:riskmgmt@co.humboldt.ca.us) for processing\*\*