REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018, FRESNO, CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

☐New Enrollment ☐Annual Enrollment
☐Name/Address ☐Change Enrollment
☐Change/Reinstatement ☐Decline Coverage
☐Retirement ☐Rehire ☐Termination

PART 1 EMPLOYEE INFORMATION

EMPLOYER	GROUP NUMBER	FOR EMPLOYER USE ONLY	FOR EMPLOYER USE ONLY
CITY OF FORT BRAGG	R01	Loc. Code: FtBragg Department Code:	Effective Date:

EMPLOYEE NAME (Last, First, MI) SS# ☐Medical ☐Dental ☐Vision

Last Name First Name MI

MAILING ADDRESS (Street, City, State, Zip) HOME PHONE ( ) BIRTHDATE: MO DAY YEAR

HIRE DATE | ANNUAL SALARY | Full Time/Part Time (Circle one) # of Hours Worked/Week : _____ | ☐MALE ☐FEMALE | ☐SINGLE ☐DIVORCED ☐MARRIED ☐SEPARATED ☐DOMESTIC PARTNERSHIP ☐WIDOWED

EMPLOYEE TERMINATION DATE | REASON FOR TERMINATION | MEDICAL PLAN SELECTION ☐EPO 250 ☐EPO 500 ☐HSA 1500 ☐BlueCard 250 (Out of state Retiree only)

PART 2 DEPENDENT INFORMATION ONLY

DEPENDENT INFORMATION (List persons to be covered/terminated.): [1] **Relationship Code (relationship to participant) SPO=**Spouse **DP=**DOMESTIC PARTNER **CHI=Child**

Add/Drop (Circle)	Last Name	First Name	MI	Social Security ** Required **	Birth Date	Gender (Circle)	Relationship Code(1)	Disabled (Circle)	Plan Selection
A D						M F	Spouse/DP	Y N	☐Medical ☐ Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐ Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐ Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐ Dental ☐Vision

IF ADDING OR DROPPING DEPENDENT, STATE REASON:

PART 3 OTHER INSURANCE INFORMATION

ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached.

Name of other policy holder	Birth Date	Social Security Number	[2] Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	[3] Benefit Types	[4] Policy Types	Coverage Date(s)
									Begin / / End / /

PERSONS COVERED UNDER ABOVE POLICY:

2 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other

3 **Benefit Type(s)**: **M**=Medical D=Dental **V**=Vision

4 **Policy Type**(s): **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

PART 4 COVERAGE DECLINATION

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

MEMBER DECLINING COVERAGE	COVERAGE DECLINED	REASON FOR DECLINING COVERAGE
Myself	☐Medical ☐Dental ☐Vision	☐ Covered by spouse's employer group plan
My Spouse/Domestic Partner	☐Medical ☐Dental ☐Vision	☐ Covered by Medicare
My Child(ren): _____	☐Medical ☐Dental ☐Vision	☐ Other: _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand if declining, I/we may have to wait until Open Enrollment to add the person(s) that is/are being declined. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If declining coverage for employee/dependent(s) please sign here. _____ Date _____

PART 5 DECLARATION

I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

_____

Employee Signature **Date**