HEALTH CARE BENEFITS CHANGE FORM

ADD DEPENDENTS

CHANGE IRS TAX STATUS OF DEPENDENT(S)

Last Name (Please Print) First Name _____ Social Security Number _____ Employee Number _____

Home Address - Street _____ City _____ State Zip _____ Email _____

Add Spouse/Domestic Partner

Add to ☐ Medical ☐ Dental ☐ Vision Effective Date: _____

Last Name First Name MI _____ Social Security Number _____ Date of birth _____

Relationship

☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female My IRS tax dependent ☐Yes ☐ No

☐ Changing from City-T to: ☐ City-Preventative ☐ Kaiser-Standard ☐ Kaiser-Deductible

Reason

☐New spouse/domestic partner (attach Affidavit of Marriage/Domestic Partnership) ☐ COBRA Coverage ended

☐Lost eligibility for other medical coverage (attach proof of other coverage) ☐ Change in IRS Tax Status ☐ **Yes** Now my IRS tax dependent. ☐ **No**

Add Dependent Child(ren

Add to ☐ Medical ☐ Dental ☐ Vision Effective Date:_____

Last Name First Name MI _____ Social Security Number _____ Date of birth _____

Relationship

Employee's Dependent **OR** **Partner's Dependent** **OR** **Other** (Step-child or Legal Guardian)

☐ Son ☐ Daughter ☐ Son ☐ Daughter ☐Male ☐ Female

Reason

☐Birth/Adoption ☐ Court order/legal guardianship. ☐ Lost other coverage (attach proof of coverage)

☐ COBRA Coverage ended ☐ Marriage/domestic partnership ☐ Other _____

☐ Changing from City-T to: ☐ City-Preventative ☐ Kaiser-Standard ☐ Kaiser-Deductible

Last Name First Name MI _____ Social Security Number _____ Date of birth _____

Relationship

Employee's Dependent **OR** **Partner's Dependent** **OR** **Other** (Step-child or Legal Guardian)

☐ Son ☐ Daughter ☐ Son ☐ Daughter ☐Male ☐ Female

Reason

☐ Birth/Adoption ☐ Court order/legal guardianship. ☐ Lost other coverage (attach proof of coverage)

☐ COBRA Coverage ended ☐ Marriage/domestic partnership ☐ Other

☐ Changing from City-T to: ☐ City-Preventative ☐ Kaiser-Standard ☐ Kaiser-Deductible

Dependent Eligibility Information: If you have listed a dependent child over the age of 26 years, please answer the questions below about your dependent:

1. Incapacitated or Disabled? ☐ Yes ☐ No

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee's Signature _____ Date _____

Revised February 2022