COUNTY OF SANTA CLARA
HEALTH CARE BONUS WAIVER PROGRAM ELECTION FORM

☐ New Hire ☐ Open Enrollment

Employee Name: _____ Normal Biweekly Hours: _____

SSN: _____ Employee ID #:_____
(From your Paycheck)

Work Phone #:_____ Home Phone #:_____

Employee Dept. Name:_____ Budget Unit #:_____

Spouse's or Same-Sex Domestic Partner's Name: _____

Does your Spouse or Partner work for the County of Santa Clara? _____ Yes _____ No

Name, Address & Telephone # of Spouse's or Partner's Employer:

_____

- I elect to participate in the County of Santa Clara Health Care Bonus Waiver Program.
- While I am enrolled in this program I will receive up to $74 per pay period in taxable earnings (amount is prorated based on standard coded hours).
- ***I acknowledge that I must re-enroll in this program during the annual open enrollment period in order to continue participation each calendar year.***
- I acknowledge that I have been offered the opportunity to enroll myself as well as my eligible dependents in a County sponsored medical plan.
- I hereby decline this opportunity in favor of participation in the Health Care Bonus Waiver Program.
- I acknowledge that I am eligible to enroll in or continue with a County sponsored dental, vision and basic life plan. (**If you want dental, vision & life, complete the BEN-02 Form and attach**)
- I certify that medical coverage is provided for myself and eligible dependents under the following plan:

Name, Address & Telephone # of Medical Plan

_____

_____

_____

NOTE: Written documentation that provides proof of medical plan coverage must be attached to this election form. A letter from your spouse's or partner's employer or medical plan provider showing the name of the plan and current dates of coverage is satisfactory proof.

A COPY OF YOUR MEDICAL PLAN CARD IS NOT ACCEPTABLE PROOF OF COVERAGE.

I authorize my employer or plan administrator to contact the above medical plan should additional information be required. I acknowledge that I am required to participate in the Health Care Bonus Waiver Program for the entire calendar year unless I experience a qualifying event as defined by the IRS. I further acknowledge that I may not enroll in a County sponsored medical plan during the normal open enrollment period in May while participating in this program.

Employee Signature: _____ Date: _____