



KERN LEGACY Network Plus

EXCLUSIVE NETWORK HEALTH PLAN

A KERN COUNTY HEALTH PLAN FOR RETIRED EMPLOYEES

MEMBER INFORMATION (Please Print)

Clear Form

EFFECTIVE DATE: _____

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	
HOME ADDRESS			DATE OF BIRTH	GENDER (M/F)
CITY	STATE	ZIP	EMAIL ADDRESS	
PHONE NUMBER	RETIREMENT DATE	DEPARTMENT	RETIREE'S PRIMARY CARE PHYSICIAN (PCP) NAME	

OFFICE USE ONLY

Retiree Name _____ Retiree Social Security Number _____

IF YOU WISH TO COVER ELIGIBLE DEPENDENTS ON YOUR RETIREE PLAN ENTER THEIR INFORMATION BELOW.

*** Be sure to attach a marriage certificate for a spouse, the certificate from the Secretary of State for a domestic partner, and birth certificates for all children you are enrolling. Additionally, for children 19, 20, 21, and 22, they must have previously been enrolled as your dependent, be enrolled in school full-time (12 or more units), and we will need a student certification.

DEPENDENT INFORMATION

DEPENDENT'S NAME	DATE OF BIRTH	GENDER (M/F)	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN
SPOUSE/DOMESTIC PARTNER				
CHILD				
CHILD				
CHILD				
CHILD				

OTHER INSURANCE INFORMATION

NAME OF SPOUSE/DEPENDENT	EMPLOYER PROVIDING GROUP HEALTH PLAN	INDIVIDUAL OR FAMILY	INSURANCE COMPANY NAME AND GROUP NUMBER

Are you or your dependent(s) eligible for Medicare? ☐ YES** ☐ NO

**If Yes, enter Name _____

RETIREE CERTIFICATION

INITIAL I have read and understand the eligibility policy and certify that any dependents listed on this form (if applicable) are eligible.

INITIAL I understand that I *may* have dependents that are eligible for coverage that I have not listed on this form. By not listing them on this form I have chosen not to enroll them at this time. I waive my right to request enrollment for such dependents until either the next open enrollment or within the 30 days following a permitting event. I understand that open enrollment is not a guaranteed annual event.

INITIAL I understand that it is my responsibility to notify Kern County Health & Wellness of any changes in eligibility either for myself or my dependents. I am aware that NO refunds of retiree premiums will be made if a dependent(s) is/are not removed timely.

INITIAL I understand that no retiree or their dependent is permitted to continue enrollment in any plan that is for participants under age 65 on or after the first day of the month in which they turn age 65.

INITIAL I understand that retiree medical plan coverage does not include the dental or vision plans available to active employees. I may wish to enroll in the retiree dental and/or retiree vision plan(s). I may wish to elect COBRA coverage for dental and/or vision, if applicable.

INITIAL I understand that I may dis-enroll at any time. If I do so, I may not re-enroll until the next open enrollment and I will forfeit any County contribution toward my coverage.

INITIAL I understand that if a retiree or their dependent becomes eligible for Medicare due to a disability, they may continue to be enrolled in the Under 65 Health Plans until they reach age 65. Once the retiree or their dependent becomes eligible for Medicare, the County Self-funded plans will only pay as a secondary plan when allowed by Medicare.

I have read and understand the foregoing statements and the Kern County and Retiree health benefits eligibility policy. I certify under penalty of perjury under the laws of the State of California that all statements are true.

Retiree/Retiree Beneficiary

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION & PAYROLL DEDUCTION

- I hereby authorize the Kern County Health & Wellness to release to exchange with and/or obtain from the Kern County Employees' Retirement Association and the County Department (or Special District) from which I retired any information necessary to process my request for retiree health coverage.
- I hereby authorize the County and the Kern County Employees' Retirement Association to make the necessary payroll deduction* from my pension check to pay for health benefits coverage for myself and my eligible, enrolled dependents

* Once the premium exceeds the total County contribution amount, the retiree will pay the difference.

Retiree/Retiree Beneficiary

Signature _____ Date _____

RETURN COMPLETED FORMS TO:



1115 Truxtun Avenue, 1st Flr
Bakersfield, California 93301