Open Enrollment Change Form
Plan Year 2027

This form is to be used by

Retired Employees COBRA Participant

enrolled in Kern County health plans

IMPORTANT:

Your completed 2027 Open Enrollment form and supporting documentation must be ***received*** by Kern County Health & Wellness no later than **5:00 p.m. on Friday, November 6, 2026**

Postmarks are not considered. Requests received after that time will not be accepted.

Fax or email forms are considered invalid and will not be processed.
All forms must have an original signature.

Please return completed forms to:

KERN COUNTY HEALTH & WELLNESS

1115 Truxtun Avenue 1st Floor, Bakersfield, California 93301

REQUIRED DOCUMENTATION FOR DEPENDENT ENROLLMENT

All Enrollees	***A Social Security Number must be furnished.*** A copy of the Social Security card is not required.
Spouses/Domestic Partners:	**A copy of a *marriage certificate/registration form* must accompany the enrollment form**.
All children:	**A copy of a *birth certificate* must accompany the enrollment form PLUS (if applicable):** For adopted children: *Court documents* indicating final adoption. If the adoption is not final, court documents dated within the six months preceding an enrollment request indicating the adoption is pending. If neither of these documents is available, contact Kern County Health & Wellness at (661) 868-3182. For Guardianships: *Court documents* indicating a guardianship has been established.

DEPENDENTS' ELIGIBILITY SUMMARY

(SEE ELIGIBILITY POLICY FOR OFFICIAL ELIGIBILITY RULES)

THE FOLLOWING DEPENDENTS ARE ELIGIBLE FOR COVERAGE

Spouse/Domestic Partner:

Employee's legal spouse or registered domestic partner

Natural or Stepchild:

Child who is under the age of 23 OR
Unmarried child age 26 or older who is permanently disabled [1]

Adopted Child:

Employee's or employee's spouse's or domestic partner's legally adopted child under the age of 23; OR
Employee's or employee's spouse's or domestic partner's unmarried legally adopted child age 23 or older who is permanently disabled [1]

Guardianships:

Unmarried child under the age of 23 for whom employee or spouse or domestic partner has legal guardianship, or had guardianship on the child's eighteenth birthday;
OR
Unmarried child age 23 or older for whom employee or spouse or domestic partner has legal guardianship and who is permanently disabled [1]

[1] Dependents age 19 or older who have never been covered by the plan may ONLY be enrolled upon employee's initial enrollment. An employee's initial hire date is their initial opportunity to enroll their eligible dependents. If not enrolled upon the initial opportunity to enroll, they cannot be enrolled subsequently if they are age 19 or older.

PLEASE NOTE:

- An incomplete form or failure to provide requested documentation will invalidate dependent's enrollment.
- Enrollment forms are subject to audit and additional documentation may be required.

KERN COUNTY HEALTH & WELLNESS

OPEN ENROLLMENT CHANGE FORM
PLAN YEAR 2027
COBRA participant

Clear Form

All changes effective January 1, 2027

SECTION 1:

PARTICIPANT'S NAME (LAST) (FIRST) (MIDDLE)	SOCIAL SECURITY NUMBER
ADDRESS:	DAYTIME PHONE NUMBER:

SECTION 2:

OPEN ENROLLMENT REQUEST(S):

- ☐ **I wish to enroll, as selected below.**
- ☐ **I wish to change medical/dental plans, as selected below.**
- ☐ **I wish to add or remove dependent(s).**

SECTION 3:

MEDICAL PLAN SELECTION:

- ☐ **Kern Legacy** SHARE SELECT
- ☐ **Kern Legacy** NETWORK PLUS
- ☐ **Kern Legacy** MAX CHOICE
- ☐ **Kern Legacy** CLASSIC CHOICE
- ☐ **Kaiser Permanente Under 65**
- ☐ **No Change**

DENTAL PLAN SELECTION:

- ☐ **Liberty CA-40R Plus Dental**
- ☐ **No Change**

VISION PLAN SELECTION:

- ☐ **Vision Service Plan (VSP)**

SECTION 4:

ACTION	LAST NAME FIRST NAME MI	SEX (M or F)	DATE OF BIRTH
☐ ADD ☐ REMOVE	SPOUSE/DOM. PARTNER SPOUSE/DOM. PARTNER SSN		
☐ ADD ☐ REMOVE	CHILD CHILD SSN		
☐ ADD ☐ REMOVE	CHILD CHILD SSN		
☐ ADD ☐ REMOVE	CHILD CHILD SSN		
☐ ADD ☐ REMOVE	CHILD CHILD SSN		

TO BE COMPLETED BY HEALTH BENEFITS DEPARTMENT:

Date of Hire	Plan Code	Effective Date: 1/01/2027

SECTION 5:

1) **Is your spouse/domestic partner a Kern County employee?** ☐ **YES** ☐ **NO**
IF YES, provide his/her Social Security Number _____ - _____ - _____

2) **Do you or any of your dependents have any other insurance or Medicare?** ☐ **YES** ☐ **NO**
IF YES, please provide information:

Name of Spouse/Domestic Partner/Dependent(subscriber)	Employer	Individual or Family Coverage	Insurance Company Name

SECTION 6:

COBRA PARTICIPANT CERTIFICATION

_____ (initial) I understand that any employee who obtains or continues County-paid coverage for any dependent who is not eligible for County-paid coverage. Such employee shall also be liable to the County for the greater of (1) actual claims paid, and (2) other costs incurred by the County for coverage provided to the ineligible dependent.

_____ (initial) I have read and understand the eligibility policy and certify that dependents listed on this form are eligible for coverage.

_____ (initial) I understand that enrollment of dependents will not occur unless required documentation is submitted with this form. If I list dependents on this form but do not attach the required documentation, the dependent will not be enrolled.

_____ (initial) I understand that this form may be selected for audit. If this form is selected for audit, I will be required to provide further documentation to verify the accuracy of the statements made on this form.

_____ (initial) I understand that it is my responsibility to notify Kern County Health & Wellness of any changes in eligibility for any of my dependents.

_____ (initial) I understand that my completed Open Enrollment Change Form and any required documents must be received by Kern County Health & Wellness **by no later than 5:00 p.m. on November 6, 2025,** or my request will **NOT** be valid.

_____ (initial) I understand that COBRA premiums will be paid directly to Kern County Health & Wellness. Newly elected coverage will only extend through my qualified election period.

SECTION 7:

I have read and understand the foregoing statements and the Kern County Health Benefits Eligibility Policy. I certify **under penalty of perjury under the laws of the State of California** that all statements made on this form are true and correct.

COBRA Participant Signature _____ Date _____

This completed form with supporting documentation must reach

KERN COUNTY HEALTH & WELLNESS

by no later than 5:00 p.m. on Friday, November 6, 2026