Opt In to Health Coverage

King County
Benefits, Payroll and Retirement Operations

- Submit this form ***within 30 days*** after loss of other benefit coverage to Benefits, Payroll and Retirement Operations, The Chinook Building CNK-ES-0240, 401 Fifth Ave., Seattle 98104-2333, or fax it to 206-296-7700.
- If you're a part-time Local 587 employee self-paying for coverage, call Benefits, Payroll and Retirement Operations for information about additional opt-in options available to you.
- Questions? Go to kingcounty.gov/benefits, e-mail kc.benefits@kingcounty.gov or call 206-684-1556.

Indicate the coverage you lost and date it ended

☐ Medical Plan name _____ Coverage end date _____

☐ Dental Plan name _____ Coverage end date _____

☐ Vision Plan name _____ Coverage end date _____

Indicate through whom you had the coverage and the reason it ended

☐ Another employer Name _____ Phone (_____)_____

Reason coverage ended _____

☐ Family member Name _____ Relationship to you _____

Reason coverage ended _____

☐ Other provider Name _____

Reason coverage ended _____

Indicate your plan if you're opting in for medical

☐ SmartCare (Kaiser) ☐ KingCare (Regence)

If you're a regular employee, full-time Local 587 employee or a part-time Local 587 employee in the Full Benefits Plan, opting in for medical coverage automatically opts you back in for dental and vision (if you don't already have the dental and vision coverage).

If you're a part-time Local 587 employee in the Partial Benefits Plan

If you're a part-time Local 587 employee in the Partial Benefits Plan, you pay monthly premiums for health coverage (medical, dental and vision). Premiums are deducted from your paycheck on an after-tax basis. If you want to opt in for dental and vision, you must opt in for each separately.

Do you want to opt in for dental? ☐ Yes ☐ No Do you want to opt in for vision? ☐ Yes ☐ No

Authorize your change

I lost coverage and want to enroll for health coverage outside regular open enrollment. I understand my request must be submitted within 30 days of loss in coverage and county coverage will begin on the first of the month following the month coverage is lost. If the conditions of my employment require me to pay monthly premiums, I understand I must pay them retroactive to the date my county coverage begins.

Employee signature _____ Date signed _____

Printed name _____ Contact phone (_____)_____

Paid ☐ 5th and 20th each month ☐ Every other Thursday PeopleSoft Employee ID _____

Office use only	Date received	Processed by	Audited by	Date effective