Dependent			
☐ Add Medical Coverage	☐ Continue Medical Coverage	☐ Decline Medical Coverage	☐ Waive Medical Coverage (Must have other group coverage or coverage through Covered CA)
☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	

Last Name:	First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified	Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No / ☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No		

Residential Address: ☐ Check Box if Same as Employee's	City:	State:	ZIP:
Mailing Address (Only if Different than Employee's)	City:	State:	ZIP:

Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Coverage; Select a Primary Care Physician (PCP) and enter the PCP ID # below.

Primary Care Physician (PCP) ID #	

If you do not provide a PCP ID # for your covered dependent(s), a Primary Care Physician will automatically be assigned

Dependent			
☐ Add Medical Coverage	☐ Continue Medical Coverage	☐ Decline Medical Coverage	☐ Waive Medical Coverage (Must have other group coverage or coverage through Covered CA)
☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	

Last Name:	First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified	Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No / ☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No		

Residential Address: ☐ Check Box if Same as Employee's	City:	State:	ZIP:
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Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Coverage; Select a Primary Care Physician (PCP) and enter the PCP ID # below.

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Dependent			
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☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	
Last Name:		First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified		Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No	☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No			
Residential Address: ☐ Check Box if Same as Employee's		City:	State: ZIP:
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Dependent			
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☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	
Last Name:		First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified		Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No	☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No			
Residential Address: ☐ Check Box if Same as Employee's		City:	State: ZIP:
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