IAFF LOCAL 935 HEALTHCARE TRUST ENROLLMENT ACKNOWLEDGEMENT FORM

Must print in Black and Blue ink ONLY

☐ New Hire ☐ Open Enrollment ☐ Change in Status: Select One Effective Date:

Employee ID	Rcd No.	Last Name, First Name	
Company	**Department**		**Telephone**

By signing below, I understand, accept and agree to the following terms and conditions:

- I acknowledge that I am enrolling in benefits under the IAFF Local 935 Fire Union Healthcare Trust (Trust) in lieu of County healthcare benefits. I understand that my election into the Trust is irrevocable for the duration of the benefit plan year; however, I will have the option to change to County healthcare benefits during Open Enrollment.
- I understand that I may elect changes to my health plans mid-year if a "Qualifying Change in Status Event" occurs, and changes must be consistent with the qualifying event. I understand that if at any time my or my family's eligibility changes, I will notify the Trust **and** HR-Employee Benefits and Services Division (EBSD) or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit elections and deductions.
- I understand that if I am covered under the benefit plans of another San Bernardino County employee, I cannot be simultaneously covered by both plans.

Employee Signature	Date

FORM MUST BE COMPLETED, SIGNED AND RETURNED TO YOUR PAYROLL SPECIALIST

Payroll Specialist Name (Print and Sign)	Date Received

Office Use Only

Authorized Representative Signature	Date

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

DISTRIBUTION: Original New Hire - EMACS-HR
Original - EBSD-HR (0440)