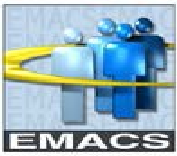

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

DEPENDENT MEDICAL PLAN
SOCIAL SECURITY NUMBER COLLECTION FORM

Must print in Black or Blue ink ONLY.

Employee ID	**Employee Name (Last Name, First Name)**	Telephone

Dependent Name (Last Name, First Name)	Date of Birth (MM/DD/YYYY)	Social Security Number

I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to my health insurance carrier for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement and disease or care management programs. The health insurance carrier's Notice of Privacy Practices is included in their evidence of coverage or certificate of insurance for coverage. A copy of this notice can be obtained by calling the health insurance carrier's member services.

I certify that, to the best of my knowledge, all information furnished by me here is true and correct.

Employee (Print & Sign)	**Date**

Please return the completed form to:
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440
Tel: (909) 387-5787 Fax: (909) 387-5566
ebsd@hr.sbcounty.gov

HR Use Only

Reviewed By (Employee ID)	Review Date	Keyed By (Employee ID)	Keyed Date