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

# MODIFIED BENEFIT OPTION ELECTION
# Teamsters/SEIU Eligible Classifications

**(Except Supervising Attorneys and Nurse Supervisory & Management Units)**

**Group:** ☐ Teamsters ☐ SEIU

**Election Type:** New Enrollment ☐ Cancellation ☐ (If cancelling skip 1-3 below)

*Must print in Black or Blue ink ONLY*

| Employee ID | Rcd No. | Last Name, First Name | Phone Number |
|---|---|---|---|
| | | | |
| **Department** | **Job Title** | | **Effective Pay Period Begin Date** |
| | | | |

*By initialing below, I understand that I am agreeing to the following conditions:*

1. By electing the MBO, I shall receive a differential in the amount of $1.75 per hour above the base rate of pay and shall receive benefits as provided in the MBO section of the MOU. *Refer to the MBO section of the MOU for details regarding benefit and pay provisions.* _____ Initial Here

2. I understand that I have the option to enroll/dis-enroll in the MBO annually during Open Enrollment or if I experience a mid-year qualifying event. _____ Initial Here

3. Please check appropriate box: I am regularly scheduled to work holidays. ☐
   I am not regularly scheduled to work holidays. ☐

*Employees who are considered regularly scheduled to work holidays are assigned to work in a facility whose operations are 24/7 (e.g. hospital) and whose assigned work schedule requires them to work on designated holidays as specified in MBO section of the MOU.*

**ELECTION AGREEMENT**

**By signing below I certify and affirm that I have read, understand, and agree to comply with the Modified Benefit Option (MBO) section of the Memorandum of Understanding.**

| Employee Signature (Print & Sign) | Date |
|---|---|
| | |

**FOR PAYROLL SPECIALIST USE ONLY**

The following information must be reviewed and verified prior to enrollment in or cancellation of the MBO:

Employee Status *(Select One)*: ☐ New Employee ☐ Open Enrollment ☐ Change in Status - Newly eligible or Cancel

Validate Classification *(Indicate if Classification is MBO eligible)*: ☐ Yes ☐ No

Indicate if employee is regularly scheduled to work holidays. ☐ Yes ☐ No

In addition to the required enrollment forms listed on the applicable payroll checklists, the following forms should be included in the MBO enrollment packet as applicable if the employee is electing to enroll in a County-sponsored medical plan (which includes the Bronze PPO Plan) and/or dental plan:

☐ Medical plan forms *(Select One)*: ☐ *Medical Plan Enrollment/Change Form*

☐ *Essential Health Plan Coverage Enrollment/Change Form (AKA Blue Shield Bronze Plan)*

☐ *Medical Expense Reimbursement (FSA) Plan Enrollment Form (if applicable)*

☐ *Dental Plan Enrollment/Change Form*

☐ *Premium Deduction Election*

| Payroll Specialist (Print & Sign) | Telephone | Date |
|---|---|---|
| | | |

*DISTRIBUTION: Original – EBSD-HR (0440)* HR 06/29/2023

**FOR HR USE ONLY**

| Keyed By (Employee ID) | Date | Pay Period Effective | Effective Date |
|---|---|---|---|
| | | | |

*This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practic 1.*