COUNTY OF SANTA CRUZ
AMENDED AND RESTATED

H-CARE: HEALTH CARE REIMBURSEMENT PLAN

CHANGE IN ENROLLMENT FORM

I hereby certify that I am a County of Santa Cruz ("County") employee currently enrolled in a group medical plan available through my employment with the County.

I have reviewed the provisions of the County of Santa Cruz Amended and Restated H-Care: Health Care Reimbursement Plan ("H-Care Plan") and wish to change my participation for the remainder of the 2008 Plan Year because the following change in status has occurred (please specify the event, the date the event occurred, and the names of the dependents involved):

I understand that I can discontinue participation in the H-Care Plan only for those specific reasons provided for in the H-Care Plan. I also understand that, should I add or drop dependents during the tax year for any reason other than those specified in the H-Care Plan, or if I do not add or drop dependents within the specific time limits provided in the H-Care Plan, my contributions to the H-Care Plan will continue at the current level. In addition, I understand that I must pay for resulting increases in contributions in after-tax dollars and that any excess withholdings for the H-Care Plan will be forfeited.

PLEASE PRINT

Employee Name: _____

Home Address: _____

_____

Social Security #: _____ Employee #: _____ Work Phone #: _____

SIGNATURE: _____ Date: _____

Return this form to: Personnel Department, Benefits Section
701 Ocean Street, Room 510, Santa Cruz