

COUNTY OF SANTA CRUZ  
AMENDED AND RESTATED

**H-CARE: MEDICAL PREMIUM PRE-TAX PROGRAM  
ENROLLMENT FORM**

~ Annual re-enrollment not required ~

I am enrolled in a County of Santa Cruz (County) offered group medical plan for the calendar year and hereby elect to participate in the County's Medical Premium Pre-Tax Program (H-CARE). I agree that my paycheck will be reduced by my medical premium share of cost, effective Pay Period One of Calendar Year 2010. If I am hired on or after Pay Period One in Calendar Year 2010, this salary deduction will be effective the first full pay period after I become an employee and am enrolled in a County offered group medical plan. This agreement will remain in effect for each succeeding pay period until it is amended or terminated.

I understand that:

- Unless there is a change in my family status specifically provided for in the H-Care Plan Document, I cannot change or revoke this benefit election prior to the next plan year and my deductions will continue at the current level.
- In the event of rate adjustments to my County provided group medical plan, my deductions for the H-Care Plan will be adjusted automatically.
- **To terminate participation, I must submit an Enrollment Revocation Form to the Benefits Office during Open Enrollment.**

**PLEASE PRINT:**

Employee Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN THIS COMPLETED FORM TO THE BENEFITS OFFICE  
BY 5:00 PM ON THURSDAY, DECEMBER 10, 2009**

**QUESTIONS? CALL THE BENEFITS HOTLINE**

by e-mail at: [benefits.questions@co.santa-cruz.ca.us](mailto:benefits.questions@co.santa-cruz.ca.us)  
or call (831) 454-2241 (press 9 to leave a message)