Southeastern California Conference
of Seventh-day Adventists
11330 Pierce Street, P.O. Box 79990
Riverside, CA 92513
(951) 509-2352

HEALTH CARE BENEFITS SUBSCRIBER
Spouse and Dependents Enrollment

Employee: _____
SS#: _____
Effective: _____

___ My family is eligible for SECC healthcare benefits. I would like to enroll my spouse and/or dependent children for following coverage. He/she has other medical coverage through his/her employer. I understand my spouse's coverage through his/her employer will be considered primary. Coverage from HCAP will be secondary.
Medical coverage through: _____

Spouse's name:_____ DOB: _____ ❑ Delta Dental ❑HCAP
Children(s) name:
_____DOB: _____ ❑ Delta Dental ❑HCAP
_____DOB: _____ ❑ Delta Dental ❑HCAP
_____DOB: _____ ❑ Delta Dental ❑HCAP
_____DOB: _____ ❑ Delta Dental ❑HCAP

___ My spouse and/or dependent children are ineligible for SECC healthcare coverage and hereby request to buy-in for medical, dental and/or vision (HCAP), for the family members listed below. I understand that changes (add/delete) can only be made at Open Enrollment for an effective date the following January. **I am authorizing payments for these benefits via payroll deductions:**

Spouse's name:_____ DOB: _____ ❑ Kaiser/ARM ❑Delta Dental ❑HCAP
Children(s) name:
_____DOB: _____ ❑ Kaiser/ARM ❑Delta Dental ❑HCAP
_____DOB: _____ ❑ Kaiser/ARM ❑Delta Dental ❑HCAP
_____DOB: _____ ❑ Kaiser/ARM ❑Delta Dental ❑HCAP
_____DOB: _____ ❑ Kaiser/ARM ❑Delta Dental ❑HCAP

Employee's Signature: _____ Date: _____