

CLACKAMAS COUNTY  
**PEACE OFFICERS' ASSOCIATION**  
 FULL TIME EMPLOYEES (30+ HOURS PER WEEK)  
 PLAN YEAR: JANUARY 1, 2011 - DECEMBER 31, 2011

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> FAMILY STATUS CHANGE	<input type="checkbox"/> OPEN ENROLLMENT	<b>EFFECTIVE DATE</b> / /2011
<b>EMPLOYEE NAME (Last, First, MI)</b>			<b>EMPLOYEE ID#</b>
<b>DEPARTMENT/DIVISION</b>			<b>SOCIAL SECURITY #</b>
<b>STATUS</b> Check all that apply:	<input type="checkbox"/> Single <input type="checkbox"/> Single w/children <input type="checkbox"/> Married <input type="checkbox"/> Family <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Domestic Partner w/ child(ren)		<b>BIRTHDATE</b>
<input type="checkbox"/> PLEASE CHECK THIS BOX IF YOUR SPOUSE OR DOMESTIC PARTNER WORKS FOR CLACKAMAS COUNTY			
<input type="checkbox"/> PLEASE CHECK THIS BOX IF YOU ARE ADDING OR DROPPING ANY FAMILY MEMBERS			

MEDICAL	EMPLOYEE ONLY	EMPLOYEE & SPOUSE/DP	EMPLOYEE & CHILD(REN)	EMPLOYEE & FAMILY
Providence – Open Option (100112-A006)	Monthly Cost: <input type="checkbox"/> \$61.17	<input type="checkbox"/> \$61.17	<input type="checkbox"/> \$61.17	<input type="checkbox"/> \$61.17
Providence – Personal Option (100112-A005)	Monthly Cost: <input type="checkbox"/> \$63.95	<input type="checkbox"/> \$63.95	<input type="checkbox"/> \$63.95	<input type="checkbox"/> \$63.95
Kaiser (1183-030-AC)	Monthly Cost: <input type="checkbox"/> \$00.00	<input type="checkbox"/> \$00.00	<input type="checkbox"/> \$00.00	<input type="checkbox"/> \$00.00

<input type="checkbox"/> <b>ODS Incentive Dental Plan</b> Group 10000174-0001-0002	<input type="checkbox"/> <b>Kaiser Dental Plan</b> Group 1183-052-AC
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<input type="checkbox"/> <b>Employee Only</b> \$75,000	<input type="checkbox"/> <b>Employee &amp; Dependents</b> \$75,000 & \$2,000
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**SUPPLEMENTAL DISABILITY (OPTIONAL)** You *must* complete a separate enrollment form when adding or dropping coverage.

Base monthly salary over \$3333 (including longevity): \$ \_\_\_\_\_ x .0054 = \$ \_\_\_\_\_ /month

**AUTHORIZATION**

I authorize Clackamas County to deduct from my paycheck the amounts necessary each month for the plan choices I have selected. I understand that these premium rates may increase or decrease in future plan years and that the County will notify me of any premium changes prior to the annual open enrollment period. I also understand that my selections can be changed during a plan year only in the event of a qualifying family status change or during the open enrollment period.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**BENEFITS USE ONLY:**

LTD	STD	EAP	ADMIN				
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