# Benefits Enrollment Form
## ADULT CHILD

King County

Benefits-eligible employees may cover their eligible children on King County benefit plans until the children reach age 26. "Children" includes stepchildren and children legally placed in your home, regardless of marital or dependent status.

King County-paid medical coverage for your adult child automatically continues until age 26. All other coverage ends when a child reaches age 23. You may elect to continue the dental, vision, life, and AD&D coverage in which your adult child is currently enrolled until they reach age 26 and pay the related premiums through payroll deduction.

Instructions: Complete, sign, date, and return to Benefits, Payroll and Retirement Operations **within 30 days** of receiving the letter notifying you of your opportunity to continue your adult child's coverage. After 30 days, your next opportunity to enroll an adult child is during annual Open Enrollment or after a qualifying life event.

### 1. Employee Information

Last _____ First _____ MI_____

Employee ID _____ Phone _____

### 2. Adult Child Information

Last _____ First _____ MI_____

Birthdate _____

### 3. Select Adult Child Coverage

Select coverage for your adult child, below. You can only elect coverage your adult child is currently enrolled in.

| | | 2024 Monthly Cost | | |
|---|---|---|---|---|
| | | **Regular Employee** | **Transit ATU 587** | **Deputy Sheriff** |
| ☐ | **Dental: Delta Dental of WA** | $57.19 | $57.55 | $55.14 |
| ☐ | **Dental: Cigna Dental HMO** | $22.00 | $22.00 | Not available |
| ☐ | **Vision** | $9.09 | $9.04 | $7.68 |
| ☐ | **Supplemental Life** | $0.901 | $0.901 | $0.901 |
| ☐ | **Supplemental AD&D** Coverage is 10% of employee coverage | $0.25 per $50,000 of employee coverage. Children receive 10% of employee amount. | | |

### 4. Acknowledgement and Authorization

The information I have provided on this form is accurate and complete. I authorize King County to make any necessary payroll deductions or refunds for my elected benefits. I affirm that my adult child meets the eligibility requirements. I understand that willful falsification of information on this form may lead to disciplinary action, up to and including discharge from employment. I understand it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Signature** _____ **Date** _____

| Office use only | Date received | Processed by | Audited by | Date effective |
|---|---|---|---|---|

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