2020-2021 Benefits Enrollment Form

Dependent Verification must be provided to the Human Resources Office at the time the enrollment form is submitted for any new dependent added during this enrollment period. Dependent Verification documents for adding spouse or domestic partner include: official marriage certificate/license issued by county agency, approved declaration of domestic partnership or most recently filed tax return showing joint filing. Dependent verification documents for children include: birth certificate, adoption paperwork, document granting legal guardianship by the court or most recently filed tax return showing child is being claimed as IRS dependent.

ACTION REQUESTED

☐ New Enrollment | ☐ Add Dependent(s) | ☐ Remove Dependent(s) | ☐ Other (specify):

Reason: ☐ Newborn ☐ Adoption ☐ Status Change ☐ Marriage/Domestic Partner Declaration ☐ New Hire ☐ Open Enrollment

EMPLOYEE INFORMATION

Last Name	First Name	Middle	Social Security Number
			- -

Street Address	City	State	ZIP	Phone Number
				( ) -

Birth Date (mm/dd/yyyy) / /	Location (School Site or Dept.):	Sex: ☐ Male ☐ Female

Date of Hire / /

Status: ☐ Academic ☐ Classified ☐ Confidential ☐ Management ☐ Board Member

HEALTH BENEFIT PLANS SELECTION
RATES ARE PER PAYCHECK AND NOT DEPENDENT ON FAMILY SIZE

Select one Medical, Dental and Vision Plan	Plan Name	Deduction Per Paycheck (10 deductions over 12 month school year)
MEDICAL PLAN OPTIONS		
☐	Anthem Blue Cross Select HMO *(Narrow Network of Physicians)*	$0.00
☐	Anthem Blue Cross CA Care HMO *(Full Network of Physicians)*	$64.00
☐	Anthem Blue Cross PPO	$482.40
☐	Kaiser Permanente $10 HMO	$196.80
☐	Kaiser Permanente $30 HMO	$0.00
☐	Waive/Opt-Out of Medical Plan	Receive Credit of $250.00
DENTAL PLAN OPTIONS		
☐	DeltaCare HMO	$0.00
☐	Delta Dental PPO	$62.39
VISION PLAN OPTIONS		
☐	EyeMed	$0.00

2020-2021 BENEFITS ENROLLMENT FORM

Please list yourself and any eligible dependents you wish to ENROLL. Please provide all information requested for each individual you are enrolling.

If enrolling in a Kaiser Permanente medical plan, ignore requests for physician name, physician ID number, medical group name and medical group ID number.

EMPLOYEE INFORMATION

Self ☐ ENROLL ☐ ADD ☐ DELETE	Anthem Primary Care Physician (PCP) Name	Anthem Primary Care Physician ID #	Existing Patient? ☐ Yes ☐ No
	Primary Care Physician's Medical Group Name		

DEPENDENT INFORMATION

Spouse/Domestic Partner ☐ ENROLL ☐ ADD ☐ DELETE	☐ Male ☐ Female	Last Name	First Name	Middle
Birth Date (mm/dd/yyyy) / /	Social Security Number - -	Address if different from Employee's		
Primary Care Physician (PCP) Name		Primary Care Physician Blue Shield ID #		Existing Patient? ☐ Yes ☐ No

Dependent 1 ☐ ENROLL ☐ DELETE	☐ Male ☐ Female	Last Name	First Name	Middle
Birth Date (mm/dd/yyyy) / /	Social Security Number - -	Address if different from Employee's		
Primary Care Physician (PCP) Name	Primary Care Physician Anthem ID #		Existing Patient? ☐ Yes ☐ No	

Dependent 2 ☐ ENROLL ☐ DELETE	☐ Male ☐ Female	Last Name	First Name	Middle
Birth Date (mm/dd/yyyy) / /	Social Security Number - -	Address if different from Employee's		
Primary Care Physician (PCP) Name	Primary Care Physician Anthem ID #		Existing Patient? ☐ Yes ☐ No	

Dependent 3 ☐ ENROLL ☐ DELETE	☐ Male ☐ Female	Last Name	First Name	Middle
Birth Date (mm/dd/yyyy) / /	Social Security Number - -	Address if different from Employee's		
Primary Care Physician (PCP) Name	Primary Care Physician Anthem ID #		Existing Patient? ☐ Yes ☐ No	

Dependent 4 ☐ ENROLL ☐ DELETE	☐ Male ☐ Female	Last Name	First Name	Middle
Birth Date (mm/dd/yyyy) / /	Social Security Number - -	Address if different from Employee's		
Primary Care Physician (PCP) Name	Primary Care Physician Anthem ID #		Existing Patient? ☐ Yes ☐ No	

PLEASE NOTE: If you elected an Anthem HMO plan and you do NOT provide a primary physician name and/or physician ID number for you or your enrolled dependents, you and any enrolled dependent will automatically be assigned to a primary care physician accepting new patients based on your residence's geographical area.

2020-2021 BENEFITS ENROLLMENT FORM

SECTION 125 ELECTION

Per IRS Section 125, your health and welfare premiums are deducted from your pay on a pre-tax basis. These premiums will be deducted from your regular compensation to pay your required contribution that you have elected, and will continue for each succeeding period until this agreement is amended or terminated. This election cannot be modified or terminated unless there is a change in family status or spouse's employment.

ACKNOWLEDGEMENTS

I acknowledge that the above represents my enrollment choices. I understand that by signing this form I am waiving or authorizing payroll deductions for any required contributions for the coverage(s) selected on the previous page. I understand that the premiums (if any) are collected after the end of the month for which I have coverage.

I understand that my elections cannot be changed or cancelled until a future open enrollment period or a qualified status change occurs, i.e., marriage, registered domestic partnership, divorce, dissolution of registered domestic partnership, birth, adoption, legal guardianship, legal custody, or a change in eligibility of a child up to age 26***.***

Appropriate documentation must be provided for all covered dependents at the time of enrollment and/or qualified event status changes, i.e., birth, adoption, guardianship, custody, marriage, domestic partner declaration, divorce, death, etc.

I represent to the best of my knowledge and belief, all statements and answers entered into this application are true, complete and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void and that I will be responsible for reimbursement of all claims paid for myself or my dependents during an ineligible period.

BY SIGNING THIS DOCUMENT, I HAVE READ & ACKNOWLEDGE THE BENEFIT MATERIALS GIVEN TO ME.

Employee Name: (Please Print) _____

Employee Signature: _____ Date: _____

2019-2020 BENEFITS ENROLLMENT/CHANGE FORM

KAISER PERMANENTE ACKNOWLEDGEMENT

Group: 10096-1 ☐ **10096-3** ☐ **Effective Date:**_____

IF YOU ARE ENROLLED IN A KAISER PERMANENTE HMO PLAN, YOU MUST REVIEW THE FOLLOWING AND SIGN.

Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of* Coverage.

Employee Name: (Please Print) _____

Employee Signature: _____ Date: _____