



## Universal Enrollment Form

### Medical/Dental/Vision - For Active, Retiree, COBRA, Surviving Spouse Participants

**FOR OFFICE USE ONLY:** Plan Type \_\_\_\_\_ Plan Code \_\_\_\_\_ Coverage Code \_\_\_\_\_ Effective Date \_\_\_\_\_

**Medical Regional Code:** Region 1 (43 Northern CA Counties) \_\_\_\_\_

Region 2 (12 Southern CA Counties including San Diego) \_\_\_\_\_ Region 3 (LA, Riverside and San Bernadino Counties) \_\_\_\_\_

**RETIREE ANNUITY STATUS:** CalPERS ID: \_\_\_\_\_ CalSTRS ID: \_\_\_\_\_

Plan Selection:				
<input type="checkbox"/> PERS Care PPO (Anthem Blue Cross)	<b>UnitedHealthCare Group Medicare Advantage PPO</b>	<b>Western Health Advantage HMO</b>	<b>Kaiser Permanente HMO</b>	<input type="checkbox"/> Delta Dental of California
<input type="checkbox"/> PERS Choice PPO (Anthem Blue Cross)	<b>Anthem Blue Cross Select HMO</b>	<input type="checkbox"/> UnitedHealthCare HMO		<input type="checkbox"/> Vision Service Plan (VSP)
<input type="checkbox"/> PERS Select PPO (Anthem Blue Cross)	<b>Anthem Blue Cross Traditional HMO</b>	<b>Health Net SmartCare HMO</b>		
<b>PORAC PPO</b> (for Police Officers Only)	<b>Blue Shield Access+ HMO</b>			

Employee Information:				
Name (Last, First, M.I.) _____	Social Security Number _____	CWID _____	Date of Birth _____	Hire Date _____
Physical Home Address (No P. O. Box) _____			Home Phone: _____	
			Alternative Phone: _____	
Sex Female      Male	Marital Status Single      Divorced      Married      Legal Separation		Classes of Coverage:	
Hrs worked per week: _____	Date of Marriage or Registration of Domestic Partnership -----		FT Faculty      Confidential PT Faculty      Police POA Classified ACE      Administrator Classified CSEA      Board Member Supervisor – TEAMSTERS	
	Job Occupation: _____	Campus Location: _____	Pre-97 Retiree Post-97 Retiree (Bridge to Medicare) Post-97 Retiree (VEBA) Surviving Spouse COBRA Enrollee	

Do you or your spouse covered under a CalPERS medical plan through another employer?  Yes     No

If yes, who is covered:  Yourself     Spouse     Dependent children

Name of the other CalPERS agency: \_\_\_\_\_

<b>MEDICAL</b>	<b>DENTAL &amp; VISION</b>
Employee Only	Employee Only
Employee + Spouse (regardless of gender)	Employee + Spouse (regardless of gender)
Employee + Same-Sex Domestic Partner* (DP/CA Registered)	Employee + Same-Sex Domestic Partner* (DP/CA Registered)
Employee + Same-Sex Domestic Partner* (DP/Non-Registered)	Employee + Same-Sex Domestic Partner* (DP/Non-Registered)
Employee + Child	Employee + Child
Employee + Children	Employee + Children
Employee + Family	Employee + Family
Employee + DP* (CA Reg) + DP's Child(ren)	Employee + DP* (CA Reg) + DP's Child(ren)
Employee + DP* (CA Reg) + EE's Child(ren)	Employee + DP* (CA Reg) + EE's Child(ren)
Employee + DP* (Non-Reg) + DP's Child(ren)	Employee + DP* (Non-Reg) + DP's Child(ren)
Employee + DP* (Non-Reg) + EE's Child(ren)	Employee + DP* (Non-Reg) + EE's Child(ren)
DECLINE	DECLINE

\*Effective 1/1/2016, new coverage for same-sex domestic partners is discontinued. Members insured prior to 12/31/2015 will be grandfathered into existing plans.

This Election is for: (Check one)	COBRA/Surviving Spouse Qualifying Event Date: (Check one)
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Marriage/Divorce: _____ <div style="margin-left: 40px;">Effective date</div> <input type="checkbox"/> Name Change: _____ <div style="margin-left: 40px;">Former name</div> <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption or Placement of Adoption Court Ordered Coverage: Please attach a copy of court order  <input type="checkbox"/> Deleting Dependent(s) <input type="checkbox"/> Loss of Other Health Coverage. Please provide termination coverage letter from other employer <input type="checkbox"/> Reinstatement of Coverage – Return from Unpaid Leave <input type="checkbox"/> Address Change <input type="checkbox"/> COBRA Continuation _____ <div style="margin-left: 40px;">Effective date</div> <input type="checkbox"/> Other: _____	Date: _____  <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Dependent reached age limit according to Plan <input type="checkbox"/> Change of Employment Hours <input type="checkbox"/> Marriage of Covered Child <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Retirement (when ineligible for District-paid benefits)

**Medical / Dental / Vision Coverage:**

(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth	Sex	Children 19 and over, IRS Dependent?	Disabled?
	Self					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse Domestic Partner					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you included stepchildren as dependents?  YES  NO If "yes" indicate name/s:

Do your stepchildren reside with you?  YES  NO

Are they dependent upon you for support and maintenance?  YES  NO

*(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)*

**Do you or your dependents have other health coverage?** If yes, please complete this section.

	Name	Name and address of other insurance Carrier	Effective Date
Self			
Spouse/DP			
Daughter/Son			

Daughter /Son			
Daughter /Son			

<b>Medicare Section</b>			
Are you retired?	Yes	No	If yes for Medicare for you and/or your Dependent(s), please provide your and/or their SSN and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).
If yes.....Part A	Yes	No	
.....Part B	Yes	No	
Do any of your dependents have Medicare?	Yes	No	SSN # _____
If yes, for your dependents.....Part A	Yes	No	Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> OTHER
.....Part B	Yes	No	Effective Date of Medicare ____/____/____
Name(s) of Medicare Dependent(s)			Name _____
_____			SSN # _____
_____			Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> OTHER
_____			Effective Date of Medicare ____/____/____
			Name _____

**HEALTH BENEFITS WAIVER:**

- I do not wish to enroll in any of the health plans offered by the District.
- I understand that if I wish to enroll in one of the District plans in the future, I can do so only during the annual open enrollment period or in the event of loss of other coverage, Marriage, Divorce, Death, Birth and/or Adoption.

Therefore, I hereby elect to decline enrollment for health coverage for myself and my dependents under Foothill-De Anza CCD CORE (Medical/Dental/Vision) benefits plan for the coming year. I understand that I will not be eligible for health benefits during the coming policy year and that this election will remain in effect until the next annual open enrollment period.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payroll Deduction Contributions**

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and the amount may change in the future.

**Kaiser Permanente Arbitration Agreement**

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between me, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my 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.

**Anthem Blue Cross PPO for PERSCare/Select/Choice, PORAC & UnitedHealthCare Group Medicare Advantage PPO:**

**Non-Participating Provider:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**Arbitration Agreement:**

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

**Your Authorization:**

I acknowledge that I have received and read the enrollment materials for the Employee Benefits Program and I have read the information on this form. I acknowledge that the information submitted represents my enrollment choice(s) and I am authorizing contributions to be withheld from my pay for the healthcare covered selected.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis.**

**I understand and agree that if I have a 10-month or 11-month assignment, my premium contribution will be collected at the earliest opportunity, and may be assessed in arrears to bring my contributions up-to-date.**

**I further understand and agree that in an event that any month in which a premium contribution is due and I have insufficient funds to meet my premium contribution, or whenever I am on non-pay status with paid benefits status such as FMLA, LTD, etc. I may enroll under the Direct Pay Plan to avoid a lapse of coverage. In such situation, I must prepay the insurance carrier directly for the full monthly health insurance premium and qualify for the monthly employer share of cost reimbursement in arrears providing that I serve the District with appropriate proof of payment and applicable invoice to validate the payment.**

**This signature also verifies the accuracy of the information on this form.**

**I have read, understand, and agree to the terms and conditions above.**

**Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_**

**Employer Information (to be completed by Human Resources Department/Benefits Unit)**

Authorized Signature of Employer : \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_