FOOTHILL-DE ANZA
Community College District

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: _____Bay Area ______ Sacramento____No. CA ___Los Angeles____So. CA_____Out-of-State

RETIREE ANNUITY STATUS: CalPERS ID: ___________________________ CalSTRS ID: __________________________

Plan Selection:

☐ PERS Care PPO (Anthem Blue Cross) ☐ PERS Choice PPO (Anthem Blue Cross) ☐ PERS Select PPO (Anthem Blue Cross)	UnitedHealthCare Group Medicare Advantage PPO Anthem Blue Cross Select HMO Anthem Blue Cross Traditional HMO Blue Shield Access+ HMO	☐ Blue Shield NetValue HMO ☐ Health Net Salud HMO y Mas Health Net SmartCare HMO	Kaiser Permanente HMO Sharp Performance Plus HMO UnitedHealthCare SignatureValue Alliance HMO	☐ Delta Dental of California ☐ Vision Service Plan (VSP)

Employee Information:

Name (Last, First, M.I.)	Social Security Number	Date of Birth	Hire Date

Physical Home Address (No P. O. Box)	Home Phone: Alternative Phone:

Sex	Marital Status	Classes of Coverage:
Female Male Hrs worked per week: _______________	Single Divorced Married Legal Separation Date of Marriage or Registration of Domestic Partnership --- Job Occupation: Campus Location: ____________________________ ________________	FT Faculty / Confidential PT Faculty / Police OE3 Classified ACE / Administrator Classified CSEA / Board Member Supervisor – TEAMSTERS Pre-97 Retiree Post-97 Retiree (Bridge to Medicare) 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: ______________________________

MEDICAL	DENTAL & VISION
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)
WAIVED	WAIVED

*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)**
☐ New Enrollment ☐ Marriage/Divorce: ____________ Effective date ☐ Name Change: ____________ Former name ☐ Birth of Child ☐ Adoption or Placement of Adoption Court Ordered Coverage: Please attach a copy of court order ☐ Deleting Dependent(s) ☐ Loss of Other Health Coverage. Please provide termination coverage letter from other employer ☐ Reinstatement of Coverage – Return from Unpaid Leave ☐ Address Change ☐ COBRA Continuation ____________ Effective date ☐ Other: ____________	Date: ____________ ☐ Termination of Employment ☐ Divorce or legal separation ☐ Dependent reached age limit according to Plan ☐ Change of Employment Hours ☐ Marriage of Covered Child ☐ Death of Subscriber ☐ 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					☐ Yes ☐ No		Yes / No
	Spouse Domestic Partner					☐ Yes ☐ No		Yes / No
	Daughter/Son					☐ Yes ☐ No		Yes / No
	Daughter/Son					☐ Yes ☐ No		Yes / No
	Daughter/Son					☐ Yes ☐ No		Yes / 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			

Medicare Section

Are you retired? Yes No If yes……………………………………Part A Yes No ……………………………………Part B Yes No Do any of your dependents have Medicare? Yes No If yes, for your dependents…………Part A Yes No ……………………………………..Part B Yes No Name(s) of Medicare Dependent(s) ______________________________ ______________________________ ______________________________	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). SSN # ______________________ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ OTHER Effective Date of Medicare ______/_______/_______ Name ______________________________ SSN # ______________________ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ 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 heatlh 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 & 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: ____________