



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 _____

Medial Regional Code: _____ Region 1 _____ Region 2 _____ Region 3 _____ Out of State

Retiree Annuity Status: STRS Pension PERS Pension CalPERS ID: _____

Plan Selection:				<input type="checkbox"/> Delta Dental* <input type="checkbox"/> VSP* <input type="checkbox"/> Employee Assistance Program* <small>* Not applicable for Part-Time Employees.</small>
<input type="checkbox"/> PERS Gold PPO (Blue Shield) <input type="checkbox"/> PERS Platinum PPO (Blue Shield) <input type="checkbox"/> Anthem Blue Cross Select HMO	<input type="checkbox"/> Anthem Blue Cross Traditional HMO <input type="checkbox"/> Blue Shield Access+ HMO <input type="checkbox"/> Blue Shield Trio HMO	<input type="checkbox"/> Kaiser Permanente HMO <input type="checkbox"/> Peace Officers Research Assoc of CA <input type="checkbox"/> UnitedHealthcare SignatureValue Alliance	<input type="checkbox"/> UnitedHealthcare SignatureValue Harmony <input type="checkbox"/> Western Health Advantage HMO	

Employee Information:			
Name (Last, First, M.I.)	CWID	Date of Birth	Date of Hire

Permanent Home Address (No PO Box)		Home Phone: Alternative Phone:
Sex <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Other: _____ Hrs worked per week _____	Marital Status <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Married <input type="radio"/> Legal Separation Date of Marriage or Registration of Domestic Partnership _____ Job Title _____	Classes of Coverage: <input type="checkbox"/> FT Faculty <input type="checkbox"/> Confidential <input type="checkbox"/> PT Faculty <input type="checkbox"/> Police OE3 <input type="checkbox"/> Classified ACE <input type="checkbox"/> Administrator <input type="checkbox"/> Classified CSEA <input type="checkbox"/> Board Member <input type="checkbox"/> Supervisor – TEAMSTERS <input type="checkbox"/> Retirees <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> COBRA Enrollees

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

If yes, who is covered: Yourself Spouse Children

Name of the other CalPERS Agency: _____

<p>Medical</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Domestic Partner*(DP/CA Registered) <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + DP* + DP's Child(ren) <input type="checkbox"/> Employee + DP* + EE's Child(ren) <input type="checkbox"/> WAIVED	<p>Dental & Vision(excluding PT)</p> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Domestic Partner*(DP/CA Registered) <input type="checkbox"/> Employee + Child <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family <input type="checkbox"/> Employee + DP* + DP's Child(ren) <input type="checkbox"/> Employee + DP* + EE's Child(ren) <input type="checkbox"/> WAIVED
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* In order to have the rights provided by State law to registered domestic partnerships, you must be registered with California's statewide registry.

Life Qualifying Event(Active employees/Retirees):	Life Qualifying Event(COBRA/Surviving Spouse):
Date: _____ <input type="checkbox"/> New Employment <input type="checkbox"/> Marriage/Divorce <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption or Placement of Adoption/Court Ordered Coverage <input type="checkbox"/> Loss of Other Health Coverage <input type="checkbox"/> Gain of Other Health Coverage <input type="checkbox"/> Reinstatement of Coverage – Return from Unpaid Leave <input type="checkbox"/> Relocation(Moving out of service area) <input type="checkbox"/> COBRA Continuation <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) <input type="checkbox"/> Unpaid Leave

Medical / Dental / Vision Coverage

(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	SSN	Date of Birth	Sex	Children 26 and over, IRS Dependent?	Disabled?
	Self					N/A	N/A
	Spouse/DP					N/A	N/A
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<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", please 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 Child, please attached 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	Other Insurance Carrier	Effective Date
Self			

Medicare Section (Applicable to retirees only)	
Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yesPart A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Do any of your dependents have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes for your dependentsPart A <input type="checkbox"/> Yes <input type="checkbox"/> No Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s) of Medicare Dependent(s): _____	If yes for Medicare for you and/or your Dependent(s), please provide your and/or their Medicare ID and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s). <hr/> Medicare ID(Self): _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Other Effective Date of Medicare: _____ <hr/> Medicare ID(Dependent): _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Other Effective Date of Medicare: _____

HEALTH BENEFITS WAIVER (Only Complete when waive)
<ul style="list-style-type: none"> 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 have a Life-Qualifying Event (LQE). <p>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. 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.</p> <p>Employee Signature: _____ Date: _____</p>

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.

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 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.

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.

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.

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

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

Employee Signature: _____

Date: _____