Reset the Form

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: _____Region 1 _____ Region 2 _____ Region 3_____Out-of-State

RETIREE ANNUITY STATUS: ◯ STRS Pension ◯ PERS Pension CalPERS ID: _____

Plan Selection:

☐ PERS Gold PPO (Anthem Blue Cross) ☐ PERS Platinum PPO (Anthem Blue Cross)	☐ UnitedHealthCare Group Medicare Advantage PPO(retiree) ☐ Anthem Blue Cross Select HMO ☐ Anthem Blue Cross Traditional HMO ☐ Blue Shield Access+ HMO	☐ Blue Shield Trio HMO ☐ Health Net Salud HMO y Mas (retiree) ☐ HealthNet SmartCare HMO	☐ Kaiser Permanente HMO ☐ Western Health Advantage HMO ☐ UnitedHealthCare SignatureValue Alliance HMO	

Employee Information:

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

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

Sex
☐ Female ☐ Male

Hrs worked per week:
_____

Marital Status
☐ Single ☐ Divorced ☐ Married ☐ Legal Separation

Date of Marriage or Registration of Domestic Partnership

Job Occupation: _____ Campus Location: _____

Classes of Coverage:
☐ FT Faculty ☐ Confidential
☐ PT Faculty ☐ Police OE3
☐ Classified ACE ☐ Administrator
☐ Classified CSEA ☐ Board Member
☐ Supervisor – TEAMSTERS

Are 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

☐ Employee Only
☐ Employee + Spouse (regardless of gender)
☐ Employee + Domestic Partner* (DP/CA Registered)
☐ Employee + Child
☐ Employee + Children
☐ Employee + Family
☐ Employee + DP* (CA Reg) + DP's Child(ren)
☐ Employee + DP* (CA Reg) + EE's Child(ren)
☐ WAIVED

*Domestic Partnership must be registered at the State level.

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) ☐ Unpaid Leave

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.

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.

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.

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: _____