Rev. 12/2024

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_____

Medial 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 (Blue Shield)** ☐ **PERS Platinum PPO (Blue Shield)** ☐ **Anthem Blue Cross Select HMO**	☐ **Anthem Blue Cross Traditional HMO** ☐ **Blue Shield Access+ HMO** ☐ **Blue Shield Trio HMO**	☐ **Kaiser Permanente HMO** ☐ **Peace Officers Research Assoc of CA** ☐ **UnitedHealthcare SignatureValue Alliance**	☐ **UnitedHealthcare SignatureValue Harmony** ☐ **Western Health Advantage HMO**	☐ **Delta Dental*** ☐ **VSP*** ☐ **Employee Assistance Program*** * Not applicable for Part-Time Employees.

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	Marital Status	Classes of Coverage:
○ Female ○ Male ○ Other: _____ Hrs worked per week _____	○ Single ○ Divorced ○ Married ○ Legal Separation Date of Marriage or Registration of Domestic Partnership _____ Job Title _____ Campus Location: _____	☐ FT Faculty ☐ Confidential ☐ PT Faculty ☐ Police OE3 ☐ Classified ACE ☐ Administrator ☐ Classified CSEA ☐ Board Member ☐ Supervisor – TEAMSTERS ☐ Retirees ☐ Surviving Spouse ☐ 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: _____

	Medical		**Dental & Vision(excluding PT)**
☐	Employee Only	☐	Employee Only
☐	Employee + Spouse	☐	Employee + Spouse
☐	Employee + Domestic Partner*(DP/CA Registered)	☐	Employee + Domestic Partner*(DP/CA Registered)
☐	Employee + Child	☐	Employee + Child
☐	Employee + Children	☐	Employee + Children
☐	Employee + Family	☐	Employee + Family
☐	Employee + DP* + DP's Child(ren)	☐	Employee + DP* + DP's Child(ren)
☐	Employee + DP* + EE's Child(ren)	☐	Employee + DP* + EE's Child(ren)
☐	WAIVED	☐	WAIVED

** In order to have the rights provided by State law to registered domestic partnerships, you must be registered with California's statewide registry.*

This Election is for:		COBRA/Surviving Spouse Qualifying Event Date:	
☐	New Enrollment		Date:_____
☐	Marriage/Divorce	☐	Termination of Employment
☐	Name Change	☐	Divorce or Legal Separation
☐	Birth of Child	☐	Dependent reached age limit according to plan
☐	Adoption or Placement of Adoption/Court Ordered Coverage	☐	Change of Employment Hours
☐	Deleting Dependent(s)	☐	Marriage of Covered Child
☐	Loss of Other Health Coverage.	☐	Death of Subscriber
☐	Reinstatement of Coverage – Return from Unpaid Leave	☐	Retirement(when ineligible for District-paid benefits)
☐	Relocation(Moving out of service area)	☐	Unpaid Leave
☐	COBRA Continuation		
☐	Other:_____		

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
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ 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? ☐ 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 Medicare ID and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

Medicare ID(Self): _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ Other

Effective Date of Medicare: _____

Medicare ID(Dependent): _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ Other
Effective Date of Medicare: _____

HEALTH BENEFITS WAIVER (Only Complete when waive)

- 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).

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.

Employee 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 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:_____**