Universal Enrollment Form

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

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: PERS ID: _________________________________ STRS ID: _________________________________

Plan Selection:

☐ **Blue Shield Access+ HMO** ☐ **Blue Shield NetValue HMO** ☐ **Kaiser Permanente HMO**	☐ **PERS Select PPO (Anthem Blue Cross)** ☐ **PERS Choice PPO (Anthem Blue Cross)** ☐ **PERS Care PPO (Anthem Blue Cross)**	☐ **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
☐ Female ☐ Male

Hrs worked per week: ____

Marital Status
☐ Single ☐ Divorced ☐ Married ☐ Legal Separation

Date of Marriage/Partnership:____
Job Occupation: ________________________Campus Location:____________________

Classification:
☐ FT Faculty ☐ PT Faculty ☐ Confidential ☐ Supervisor ☐ Classified ACE ☐ Administrator
☐ Classified CSEA ☐ Board Member ☐ Retiree ☐ Surv. Spouse ☐ OE3 ☐ COBRA Enrollee

MEDICAL

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Same-Sex Domestic Partner (DP/CA Reg)
☐ Employee + Same-Sex Domestic Partner (DP/Non-Reg)
☐ Employee + Child
☐ Employee + Children
☐ Employee + Family
☐ Employee + DP (CA Reg) + DP's Child(ren)
☐ Employee + DP (CA Reg) + EE's Child(ren)
☐ Employee + DP (Non-Reg) + DP's Child(ren)
☐ Employee + DP (Non-Reg) + EE's Child(ren)
☐ WAIVED

DENTAL & VISION

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Same-Sex Domestic Partner (DP/CA Reg)
☐ Employee + Same-Sex Domestic Partner (DP/Non-Reg)
☐ Employee + Child
☐ Employee + Children
☐ Employee + Family
☐ Employee + DP (CA Reg) + DP's Child(ren)
☐ Employee + DP (CA Reg) + EE's Child(ren)
☐ Employee + DP (Non-Reg) + DP's Child(ren)
☐ Employee + DP (Non-Reg) + EE's Child(ren)
☐ WAIVED

This Election is for:

☐ New Enrollment

☐ Marriage/Divorce: __________________________
Effective date

☐ Name Change: _____________________________
Former name

COBRA/Surviving Spouse Qualifying Event Date:
____

☐ Termination of Employment
☐ Change of Employment Hours
☐ Death of Subscriber
☐ Divorce or legal separation

☐ ☐	Birth of Child Adoption or Placement of Adoption (Court Ordered Coverage: Please attach a copy of court order)	☐ Dependent reached age limit according to PLAN ☐ 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	Gender	Disabled?
	☐ Spouse ☐ Domestic Partner					
	Daughter/Son					
	Daughter/Son					
	Daughter/Son					

Do your children reside with you? ☐ YES ☐ NO

If no, your children's physical address is :____

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

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).

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)

____

____

____

Retiree:

SSN # ____________________________________
Entitlement Reason:
☐ Over 65
☐ Disabled
☐ OTHER
Effective Date of Medicare ______/_______/_______

Dependent(s):

SSN # ____________________________________

Name ______________________________________
Entitlement Reason:
☐ Over 65
☐ Disabled
☐ OTHER
Effective Date of Medicare ______/_______/_______

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.

HMO 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.

PPO 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.

Active employees only: 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.

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

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

Subscriber Signature: ___________________________________ Date: _______________________

Employer Information (to be completed by Human Resources Department)

Authorized Signature of Employer:____

Effective Date of Coverage: ____