FOOTHILL-DE ANZA
Community College District

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		**DENTAL & VISION**
☐	Employee Only	☐	Employee Only
☐	Employee + Spouse	☐	Employee + Spouse
☐	Employee + Same-Sex Domestic Partner (DP/CA Reg)	☐	Employee + Same-Sex Domestic Partner (DP/CA Reg)
☐	Employee + Same-Sex Domestic Partner (DP/Non-Reg)	☐	Employee + Same-Sex Domestic Partner (DP/Non-Reg)
☐	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

	This Election is for:	**COBRA/Surviving Spouse Qualifying Event Date:**
☐	New Enrollment	_____
☐	Marriage/Divorce: _____ Effective date	☐ Termination of Employment ☐ Change of Employment Hours
☐	Name Change: _____ Former name	☐ Death of Subscriber ☐ Divorce or legal separation

☐	Birth of Child	☐	Dependent reached age limit according to PLAN
☐	Adoption or Placement of Adoption (Court Ordered Coverage: Please attach a copy of court order)	☐	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: _____

California Public Employees' Retirement System
P.O. Box 942715
Sacramento, CA 94229-2715

HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS-HBD-12 (Rev. 6/13)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

CalPERS **USE ONLY - DOCUMENT REFERENCE NUMBER**

PLEASE TYPE

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER ___ ___

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER ___ ___

4A. Name (FIRST) (MI) (LAST)

Mailing Address

City, State, ZIP | Daytime Phone | Evening Phone

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Reason Code

15. Permitting Event Date Mo. Day Yr.

16. EFFECTIVE DATE Mo. Day Yr. 01

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo. Day Yr.	Family Relationship	GENDER M F	CODE
	17. BASIC PLAN (FIRST) (MI) (LAST)		SELF		
	SSN				
	(FIRST) (MI) (LAST)				
	SSN				
	(FIRST) (MI) (LAST)				
	SSN				
	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo. Day Yr.	Relationship		CODE

19. CHECK ONE

- ☐ I **DO NOT** elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)

TELEPHONE NUMBER ( )

21. DATE SIGNED Mo. Day Year

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office Mo. Day Year

34. PHONE NUMBER

35. REMARKS

_____ of _____ Forms

WHITE – HB PINK – Agency BLUE - Employee

PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, Health Account Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.

CalPERS

Office of Employer and Member Health Services
PO Box 942714
Sacramento, CA 94229-2714
Toll Free: (888) CalPERS (225-7377) Fax: (916) 795-1313
Telecommunications Device for the Deaf: (916) 795-3240

Declaration of Health Coverage: HBD-12A **(INSTRUCTIONS ON REVERSE)**

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST) (MIDDLE) (LAST)

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. **If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**
PART B-2 ☐ I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. **You must wait at least 90 days after you request enrollment or until the next Open Enrollment period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature

Date Signed

Health Benefits Officer's Signature

Rev (3/09)

Original: Employee's Personnel File

Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HB-12A	
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not eligible to be enrolled in a CalPERS-sponsored health plan on the date you separate employement, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are enrolled on your CalPERS-sponsored health plan at this time, they may be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.