FOOTHILL-DE ANZA
Community College District

Universal Enrollment Form

Medical - For PT Faculty w/o REP and Temporary Classified Participants

FOR 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

CalPERS ID: _____ CalSTRS ID: _____

Plan Selection:

☐ **PERSCare PPO (Anthem Blue Cross)** ☐ **PERS Select PPO (Anthem Blue Cross)** ☐ **PERS Choice PPO (Anthem Blue Cross)**	☐ **Blue Shield Access+ HMO** ☐ **Blue Shield NetValue HMO** ☐ **Health Net Salud HMO y Mas** ☐ **Health Net SmartCare HMO**	☐ **Kaiser Permanente HMO** ☐ **Sharp Performance Plus HMO** ☐ **UnitedHealthcare SignatureValue Alliance HMO**	☐ **Anthem Blue Cross Select HMO** ☐ **Anthem Blue Cross Traditional HMO**	

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	Marital Status	Classes of Coverage:
☐ Female ☐ Male Hours worked per week: _____	☐ Single ☐ Divorced ☐ Married ☐ Legal Separation Date of Marriage or Registration of Domestic Partnership ---------- Job Occupation: _____ Campus Location: _____	☐ PT Faculty (0.400+ load w/o REP) ☐ TEA (casuals w/20+ hours plus 6 mo & 1 day ☐ COBRA Enrollee

Do 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		COVERAGE CODE		
☐	Employee Only				
☐	Employee + Spouse (regardless of gender)				
☐	Employee + Same-Sex 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				

This Election is for: (Check one)		**COBRA/Surviving Spouse Qualifying Event Date: (Check one)**
☐	New Enrollment	Date: _____
☐	Marriage/Divorce: _____ Effective date	☐ Termination of Employment
☐	Name Change: _____ Former name	☐ 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	☐ Change of Employment Hours
☐	Deleting Dependent(s)	☐ Marriage of Covered Child
☐	Loss of Other Health Coverage. Please provide termination coverage letter from other employer	☐ Death of Subscriber
☐	Reinstatement of Coverage – Return from Unpaid Leave	☐ Retirement (when ineligible for District paid benefits)
☐	Address Change	
☐	COBRA Continuation _____ Effective date	
☐	Other: _____	

Medical 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 (Registered)					☐ 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 sponsored health plan for the plan year (January-December). 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.

Kaiser Permanente 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.

Anthem Blue Cross PPO for PERSCare/Select/Choice:

Non-Participating Provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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.

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 hereby authorize Foothill-De Anza Community College District to collect my monthly contribution applicable for the coverage I have elected. I understand and agree that for the Benefits Plan Year (January – December) my monthly contributions must be prepaid and collected via payroll in advance (for example, July coverage is collected in June pay) via regular payroll periods as pre-tax deductions when in pay status. I understand that whenever I am in non-pay status, for any month a contribution payment is due, my plan will cease accordingly. Thereafter, COBRA will be offered for a maximum period of 18 months via self-pay to the insurance carrier directly, not CalPERS or FHDA. I further understand and agree that in an event that the required employee contribution exceeds compensation in any regular pay period, you may request for a drop of coverage or transition to a Direct Pay Plan via self-pay with the carrier. In either situation, the monthly employer share of cost is discontinued. I understand and agree that ALL payment must be made on or before the due date for which the contribution is applicable. I understand that these employee contributions for my selected health care plan remain in effect unless I terminate employment or change my election as permitted under the plan (e.g. due to a change in family status or during a special enrollment period).

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: _____