UNIVERSAL BENEFIT RE-ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM WILL BE EFFECTIVE 09/01/08 - 02/28/09

******ADJUNCT EMPLOYEES ONLY******

COMPLETE SECTIONS 1-8 AND RETURN TO THE BENEFITS OFFICE

NO LATER THAN MONDAY, SEPTEMBER 15, 2008

PERALTA COMMUNITY COLLEGE DISTRICT

1. EMPLOYEE INFORMATION *(Please Print)*

Employee Name *(last name, first name, middle initial)*

Employee Address (street, city, state, zip code)

SHADED AREA FOR OFFICE USE ONLY:

EFFECTIVE DATE:	September 1, 2008
MEDICAL GROUP/DIVISION #:	Kaiser: 65-51 or Coresource: Grp 2 Div 49
DENTAL GROUP/DIVISION #:	Delta: 938-1501 or UHC DMO: 04N6331
FORM REVIEWED & APPROVED BY:	
DATE REVIEWED & APPROVED:	

Home Phone:		Alternate Phone:	Email Address:		
Work Location	Occupation **Adjunct Prof**	Social Security Number:	Date of Birth	Date of Hire:	Date of Retirement:
Hours/Week	Gender	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow ☐Domestic Partner			

2. INDIVIDUALS COVERED

(A)dd (C)hange (D)rop	Name	Social Security Number	Date of Birth	Sex	Relationship: Spouse, Domestic partner, Child-natural, Child-foster, Child-adopted	Totally Disabled?	IRS Dependent?	Medical/ Vision	Dental
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		
						☐Yes ☐No	☐Yes ☐No		

3. BENEFIT PLANS

•MEDICAL/ VISION

Choose one:

☐ Kaiser Permanente HMO
☐ Kaiser Senior Advantage HMO
☐ Coresource PPO/Vision*

*Pre-existing condition limitations apply; 6 months for new hires; 18 months for late entrants

Division Name: Adjunct
Group #:2 / Division #:49

☐ Medicare Coverage
☐Part A Only ☐Part B Only ☐Parts A&B

Please refer to the Enrollment Affidavit for a breakdown of premiums and your costs.

Choose one:

(1) Employee only
☐**Kaiser**
☐**Coresource**
(2) Employee + 1 dependent
☐**Kaiser**
☐**Coresource**
(3) Employee + family
☐**Kaiser**
☐**Coresource**

•DENTAL

Choose one:

☐ Delta PPO Dental
☐ UHC DMO Dental *(MUST designate DMO Provider)*

Name of UHC DMO Provider:____________________
DMO Provider #:____________________________

(You may obtain the DMO provider # by calling Customer Service at 800-999-3367)

Please refer to the Enrollment Affidavit for a breakdown of premiums and your costs.

Choose one:

(1) Employee only
☐**Delta Dental**
☐**UHC Dental**
(2) Employee + 1 dependent
☐**Delta Dental**
☐**UHC Dental**
(3) Employee + family
☐**Delta Dental**
☐**UHC Dental**

Unless you check below, your premium WILL be deducted on a pre-tax basis from your PCCD pay:
☐ **I do NOT wish to have my premiums deducted on a pre-tax basis.**

Signature____**Date**______________________________

Print First Name________________________ **Print Last Name**______________________________