

Peralta Community College District Benefits Enrollment Checklist

(Special Note to Part Time and Hourly faculty: Include documentation of all full time equivalent (FTE) for Academic Term)

(Shaded portion of the form does not apply to Part Time and Hourly faculty Employees)

Rev. 12/20/12

You may download forms from our Benefits Information Center website (link provided below) or contact the Benefits Office for hard copies.

Information Received	Website Links
1. Part Time and Adjunct Benefit Open Enrollment Announcement includes COBRA Notice	www.peralta.pswbenefits.net
2. Kaiser Packet	
3. Kaiser Disclosure & Plan Highlights	
4. Peralta PPO "Traditional" & PPO "Lite" Summary Plan Description—Actives	
5. Application of Pre-Existing Condition Exclusion	
6. Peralta PPO Caremark—List of Pharmacies	
7. Peralta PPO Caremark—Mail Order Prescriptions	
8. UnitedHealthCare Vision Care Benefits	
9. Delta Dental Overview	
10. Delta Dental Evidence of Coverage	
11. UnitedHealthCare Dental Lists / Costs	
12. Flexible Benefits Plan Medical & Dependent Care Program	
13. Section 132 Pre-Tax Parking & Commuter	
14. Voluntary & Prepaid Legal Plan Overview & Service List	
15. Tax-Deferred 403(b) & 457 Highlights & Comparison 2013	www.peralta.edu
16. Life Insurance Overview	www.peralta.pswbenefits.net
17. Employee Assistance Program Overview	
18. Life Insurance Certificate of Coverage	
19. Long Term Disability Overview	
20. Long Term Disability Certificate of Coverage	
21. Voluntary Term Life CIGNA Overview	
The following forms MUST be returned within 31 days from date of hire or state date (whichever occurs later) <i>Received by Benefits Office or N/A</i>	
22. Part Time and Hourly Faculty Universal Enrollment Form	www.peralta.pswbenefits.net
23. Pre-Existing Exclusion Application	www.peralta.pswbenefits.net
24. Flexible Benefits Plan Enrollment Medical & Dental	
25. CIGNA Voluntary Life Insurance Application	www.peralta.pswbenefits.net
26. Cash in Lieu of Benefits Form	www.peralta.pswbenefits.net
The following forms may be returned at any time:	
27. Pre-Tax Commuting Enrollment	www.peralta.pswbenefits.net
28. Pre-Paid Legal Enrollment Form	www.peralta.edu
29. Salary Reduction Agreement Form 403(b) & 457	
<p>WAIVER AND ACKNOWLEDGEMENT: I have read & understand my options. If I enroll in a group insurance plan, I agree to notify the District within 30 days of a qualifying event. If I do not enroll now, I understand that I may enroll at a later date subject to open enrollment provisions. If payroll deductions are required for medical or dental, I agree that they will be pre-tax and I will advise PCCD if I prefer after tax deductions. I agree to pay accordingly.</p>	
Signature: _____	Date: _____

UNIVERSAL BENEFIT ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM WILL BE EFFECTIVE 03/01/13 - 08/31/13

PERALTA COMMUNITY COLLEGE DISTRICT



333 East 8th Street
Oakland, CA 94606

*****PART TIME AND HOURLY FACULTY EMPLOYEES ONLY*****

COMPLETE SECTIONS 1-8 AND RETURN TO THE BENEFITS OFFICE

(Allow 10 days for processing adds and drops)

NO LATER THAN FRIDAY, FEBRUARY 22, 2013

1. EMPLOYEE INFORMATION (please print)		
Employee Name (last name, first name, middle initial)	SHADED AREA FOR OFFICE USE ONLY:	
	EFFECTIVE DATE:	March 1, 2013 Other _____
Employee Address (street, city, state, zip code)	MEDICAL GROUP/DIVISION #:	Kaiser: 65-51 or 65-68 Peralta PPO: Division 25 Account 109, 110, 113 or Division 02 Account 109, 110, 113
	DENTAL GROUP/DIVISION #:	Delta Dental: 938-1501 or UHC DMO: 729309-0012
	FORM REVIEWED & APPROVED:	
	DATE REVIEWED & APPROVED:	
Home Phone:	Alternate Phone:	Email Address:
Work Location:	Occupation: Part Time and Adjunct Prof.	Social Security Number
Date of Birth:	Date of Hire:	Date of Retirement:
Hours/Week:	Gender	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow

2. INDIVIDUALS COVERED									
(A)dd (C)hange (D)rop	Last Name, First Name	Social Security Number	Date of Birth	Sex	Relationship Spouse Domestic Partner Child - natural Child - foster Child - adopted Child—Overage Dep.	Totally Disabled?	State Type of Document Attached: •Copy of most recent tax return •Proof of relationship •Proof of join ownership •Other	Medical	Dental
						<input type="checkbox"/> Y <input type="checkbox"/> N			
						<input type="checkbox"/> Y <input type="checkbox"/> N			
						<input type="checkbox"/> Y <input type="checkbox"/> N			
						<input type="checkbox"/> Y <input type="checkbox"/> N			

If dropping dependents, please specify reason:

3. BENEFIT PLANS			
<ul style="list-style-type: none"> MEDICAL VISION PHARMACY 	<p>Choose one:</p> <p><input type="checkbox"/> Kaiser Permanente HMO (51 or 68)</p> <p><input type="checkbox"/> Peralta PPO "Traditional" (In and Out-of-Network Benefits) (participation in the Anthem Blue Cross Network) Division Name: Hourly faculty Division #: 25 Account #: 109 or 110 Division #: 02 Account #: 109 or 110</p> <p><input type="checkbox"/> Peralta PPO "Lite" (In--Network Benefits ONLY) (participation in the Anthem Blue Cross Network) Division Name: Hourly faculty Division #: 25 Account #: 113 Division #: 02 Account #: 113</p> <p>Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs. *Pre-Existing limitations apply; 6 months for new hire, 18 months for late enrollment.</p>	<p>Choose one:</p> <p>(1)Employee Only <input type="checkbox"/> Kaiser <input type="checkbox"/> Peralta PPO "Traditional" <input type="checkbox"/> Peralta PPO "Lite"</p> <p>(2)Employee + 1 dependent <input type="checkbox"/> Kaiser <input type="checkbox"/> Peralta PPO "Traditional" <input type="checkbox"/> Peralta PPO "Lite"</p> <p>(3)Employee + family <input type="checkbox"/> Kaiser <input type="checkbox"/> Peralta PPO "Traditional" <input type="checkbox"/> Peralta PPO "Lite"</p>	
<ul style="list-style-type: none"> DENTAL 	<p>Choose one:</p> <p><input type="checkbox"/> Delta PPO Dental</p> <p><input type="checkbox"/> UHC DMO Dental (<i>MUST</i> designate DMO provider) Name of DMO Provider: _____ DMO Provider #: _____ (You may obtain the DMO provider # by calling Customer Service at 800-999-3367) Please refer to the Eligibility Affidavit for a breakdown of premiums and your costs.</p>	<p>Choose one:</p> <p>(1)Employee Only <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental</p> <p>(2)Employee + 1 dependent <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental</p> <p>(3)Employee + family <input type="checkbox"/> Delta Dental <input type="checkbox"/> UHC Dental</p>	

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 _____

*****Please attach Instructor Term Workload printout from PROMT*****

4. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? Yes No If yes, Medicare # _____ (attach a copy of the Medicare card)
If yes, who? _____
2. Is anyone listed eligible for Medicaid or CHIP? Yes No ID# _____
If yes, who? _____
3. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months? Yes / No If yes, complete the section below. Please list all current or prior medical coverage. Failure to provide complete information may result in significant delay of claims processing (attach additional sheets if necessary).

COVERED PERSON'S NAME (last, first, M.I.)	Policy Holder's Name	Insurance Company Name	Type of Coverage	Policy #	Termination Date (if applicable)
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Health <input type="checkbox"/> Other: _____		

5. KAISER ENROLLEES MUST READ AND SIGN:

Check if **NOT** enrolling in Kaiser

Kaiser Foundation Health Plan Arbitration Agreement:

I 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 myself, 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.

EMPLOYEE SIGNATURE

DATE

6. PERALTA SELF-FUNDED PLAN ENROLLEES MUST READ AND SIGN:

Check if **NOT** enrolling in a Peralta Self-Funded plan

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.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and the Plan for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and the Plan are giving up the right to have any dispute decided in a court of law before a jury. The Plan and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

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.

A group health plan makes coverage effective on the first of the month following your initial date of hire and on each *open enrollment period* following. Open enrollment generally occurs in February and August of each calendar for adjunct employees and in May of each year for all other employees.

The District's self-funded plan administered by CoreSource imposes a 6-month maximum pre-existing condition exclusion (18 months for late enrollees) and uses a 6-month look back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment recommended or received within a 6-month period. Generally, this 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 6 months (18 months if you are late enrollee) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

Health Care Reform removed the pre-existing condition requirement for members under the age of 19.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to:

Benefits Office, Peralta Community College District, 333 East 8th Street, Oakland, CA 94606, Phone number: 510-466-7229, Email: benefits@peralta.edu

EMPLOYEE SIGNATURE

DATE

7. COMPLETE THE APPLICABLE SECTION BELOW TO DETERMINE YOUR TOTAL PER PAY PERIOD DEDUCTION:

50/50 Plan - see below for premium rates in effect from 3/1/13–8/31/13:

Medical Premium \$ _____ + 2 = \$ _____ X 6 = \$ _____ + 3 = \$ _____ (your monthly share)
 + Dental Premium \$ _____ X 6 = \$ _____ + 3 = \$ _____ (your monthly share)

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: \$ _____ (your monthly share)

100% Plan - see below for premium rates in effect from 3/1/13–8/31/13:

Medical Premium \$ _____ X 6 = \$ _____ + 3 = \$ _____ (your monthly share)
 + Dental Premium \$ _____ X 6 = \$ _____ + 3 = \$ _____ (your monthly share)

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: \$ _____ (your monthly share)

PREMIUM RATES

Current 07/01/12 Monthly
Premium Rates

Benefits Office Use Only

	<u>Medical</u>	<u>Dental</u>
Oct	<input type="checkbox"/>	<input type="checkbox"/>
Nov	<input type="checkbox"/>	<input type="checkbox"/>
Dec	<input type="checkbox"/>	<input type="checkbox"/>

Medical PPO (Self Funded)

	<u>Traditional</u>	<u>Lite</u>
Single:	\$ 729.10	\$ 666.55
Two Party:	\$1,628.99	\$1,489.24
Three Party:	\$2,447.27	\$2,237.32

Medical HMO (Kaiser)

Single:	\$ 622.64
Two Party:	\$1,245.27
Three Party:	\$1,762.06

Dental PPO (Delta)

Single:	\$ 74.29
Two Party:	\$ 126.30
Three Party:	\$ 193.17

Dental DMO (UnitedHealthcare)

Single:	\$ 26.95
Two Party:	\$ 43.11
Three Party:	\$ 65.69

8. TERMS AND AGREEMENT (ALL EMPLOYEES MUST SIGN AND DATE BELOW):

In exchange for my enrollment, I agree to notify the District in writing within 30 days of the following:

1. My change of address
2. Change to my marital status resulting in adding or deleting a spouse or domestic partner
3. Change to my eligible dependents status such as adding a newborn, or adopted child
4. Change to my ineligible dependents status such as deleting an overage dependent
5. Naming ineligible dependents may result in repaying District premium or claim costs per Board Policy 3.86
6. If adding a domestic partner, I may not be subject to imputed California State income tax per tax regulations if I submit a California State Registration of Domestic Partnership. My domestic partner is a registered domestic partner and I have attached a California State Registration of Domestic Partnership, is not a registered domestic partner, does not apply
7. Failure to notify the District of change in dependent status may result in actions stated in item #5 above.
8. Enrollment subject to post enrollment audit
9. I agree to pay premiums based on my plan election.

I also acknowledge that in accordance with Peralta Community College District Board Policy, civil action may be brought against employees who make false statements or fail to notify the District of change in dependent status.

I agree to pay premium directly from my Peralta Community College District pay. If there are insufficient earnings, I will pay for benefits by personal check within the first 10 days of the coverage month or face cancellation of coverage for non-payment of premium. I understand that I am subject to post-enrollment premium payment audits and may owe for unpaid premiums at the end of the enrollment period. I am subject to imputed income if enrolling a Domestic Partner.

I understand the "your monthly share" as referenced in section 7 above.

I understand that re-enrollment for future semesters is not automatic and that I need to resubmit each semester for which I am eligible.

EMPLOYEE SIGNATURE

DATE

**Peralta Community College
Eligibility Affidavit
50% / 50% and 100% Plan
Spring 2013**

RETURN THIS FORM TO THE PERALTA BENEFITS OFFICE NO LATER THAN **FRIDAY, FEBRUARY 22, 2013**. INCOMPLETE OR FORMS RECEIVED AFTER THIS DATE WILL BE PROCESSED IN ACCORDANCE WITH QUALIFYING EVENTS AS DEFINED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974. FORMS ARE ACCEPTED WITHIN 30 DAYS OF A QUALIFYING EVENT (SUCH AS LOSS OF COVERAGE UNDER ANOTHER GROUP PLAN)

Section A: Personal Information

Employee's Name (Last, First, Middle Initial) - please print	Social Security Number	Date of Birth
Street Address - please print	City	State
Telephone Number (home)	Telephone Number (work)	Email Address

Check here if the above reflects any new / updated contact information.

Section B: Affidavit of Eligibility

Please answer Yes or No to questions 1, 2, and 3. Initial next to your response.

1. Are you currently employed by PCCD as any hourly faculty member? Yes No _____ (your initials here)
2. Do you have a fall assignment of 40% or greater? Yes No _____ (your initials here)
(refer to the Instructor Assignment Roster—**attach the Spring 2013 Workload to this form**)
3. Do you have other access to group medical insurance where all or part of the premium is paid through some source other than personal funds or a Community College District? Yes No _____ (your initials here)

Section C: Benefit Options—Circle your Choices and Attach Part Time and Hourly Faculty Universal Enrollment Form

Coverage 50% / 50% Plan	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments <u>Kaiser</u> Monthly Rate/Payroll Rate	Your 50% / 50% Monthly Share: 6 months of coverage paid in 3 installments <u>Self Funded PPO</u> Monthly Rate/Payroll Rate	Coverage 100% Plan	Your 100% Monthly Share: 6 months of coverage paid in 3 installments <u>Kaiser</u> Monthly Rate/Payroll Rate	Your 100% Monthly Share: 6 months of coverage paid in 3 installments <u>Self Funded PPO</u> Monthly Rate/Payroll Rate
Single	\$311.32mo; \$622.64/pr	TrdnI \$364.55/mo; \$729.10/pr ◆ Lite \$333.28/mo; \$666.55/pr	Single	\$622.64/mo; \$1245.28/pr	TrdnI \$729.10/mo; \$1458.20/pr ◆ Lite \$666.55/mo; \$1333.10/pr
Two Party	\$622.64mo; \$1245.28/pr	TrdnI \$814.50mo; \$1628.99/pr ◆ Lite \$744.62/mo; \$1489.24/pr	Two Party	\$1245.27/mo; \$2490.34/pr	TrdnI \$1628.99/mo; \$3257.98/pr ◆ Lite \$1489.24/mo; \$2978.48/pr
Three Party	\$881.03/mo; \$1762.06/pr	TrdnI \$1223.64/mo; \$2447.27/pr ◆ Lite \$1118.66/mo; \$2237.32/pr	Three Party	\$1762.06/mo; \$3524.02/pr	TrdnI \$2447.27/mo; \$4894.54/pr ◆ Lite \$2237.32/mo; \$4474.64/pr
Coverage Employee makes 3 installments for 6 months of coverage		Delta Dental PPO Dental Plan You pay full monthly premium		United HealthCare DMO Dental Plan You pay full monthly premium	
Single		\$74.29		\$26.95	
Two Party		\$126.30		\$43.11	
Three Party		\$193.17		\$65.69	

Section D: Payroll Deduction Authorization

I understand that if I waive coverage or do not enroll in coverage, I can enroll at a later date if there is a QUALIFYING EVENT as permitted and defined by HIPAA governances.

50% / 50% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the above-referenced CIRCLED amounts from my monthly paycheck to pay for 50% of the medical premium cost and 100% of the dental premiums for the amount of coverage I have selected. Deductions will occur for the 3 pay periods **March, April, May 2013**. _____
(please sign and date)

OR

100% Plan: I hereby authorize Peralta Community College District Payroll Department to deduct the above-referenced CIRCLED amounts from my monthly paycheck to pay for 100% of the medical and/or dental premium cost for the amount of coverage I have selected. Deductions will occur for the 3 pay periods **March, April, May 2013**. I do not qualify for the District contribution and agree to pay 100% of the above-referenced circled premium. _____
(please sign and date)

Section E: Complete and Attach Required Forms to the Affidavit:

Term Workload Assignment , Part Time and Hourly Faculty Benefit Checklist & Universal Enrollment Form Checklist are attached to this Affidavit. _____
(initial here)

Application of Pre-Existing Condition Exclusion (for medical plan enrollment)

Submit this form with the Part Time and Hourly faculty Universal Enrollment Form

August 2012

If enrolling on the Kaiser plan, complete sections A & C.
If enrolling on a Self Funded PPO plan, complete sections A through C.

SECTION A

Employee and/or Dependent Name(s):

- PART TIME HOURLY FACULTY ONLY: check here if enrolling in dental coverage only.
PART TIME HOURLY FACULTY ONLY: check here if enrollment is continuing from Spring 2012 semester.

Hire date:

First eligible to enroll date:

Definition of Pre-Existing Condition: medical advice, diagnosis, care, or treatment recommended or received within a 6 month period. Generally, this 6 month period ends on the day before the waiting period begins.

SECTION B

As required under Federal law, we advised you and your eligible dependent(s) of contractual pre-existing condition exclusions under the self-funded plan (currently administered by CoreSource) offered by Peralta Community College District. Submit any evidence of prior coverage along with your Universal Enrollment form and within 30 days of coverage effective date. PCCD will only accept the Certificate of Creditable Coverage as issued from your prior insurer. Ask your former group insurance administrator for this Certificate. Your prior insurer is required to provide it upon request. PCCD will assist you acquiring this document from the prior carrier or employer should you so request, in writing.

Your pre-existing condition exclusion period may be reduced by prior creditable coverage as defined by the law. As of this date, you have:

- Submitted the Certificate of creditable coverage and have satisfied the pre-existing conditions limitation period in full. Evidence is attached.
Not submitted any evidence of prior creditable coverage. Therefore, the full limitation period applies.
6 months (timely enrollee) 18 months (late enrollee)
Submitted certification of prior creditable coverage. This totals days/months for all persons to whom this notice applies. This time can be used to offset the pre-existing condition exclusion period of our plan. Therefore, you will only be subject to days/months of limitation for pre-existing conditions from your date of hire (this includes any applicable waiting period).

You have the legal right to submit further certification of prior waiting periods and creditable coverage as it becomes available. If you disagree with the findings of this notice, please submit your disagreement, in writing to: District Benefits Office, Peralta Community College District, 333 East 8th Street, Oakland, CA 94606, Phone number: 510 466-7229, Email: benefits@peralta.edu

Note: Should your claims be denied in whole or in part by the insurance company based on the application of a pre-existing conditions limitation in excess of that stated above, contact Benefits Office for assistance in resubmitting your claim.

SECTION C

I understand that if I am enrolling in the self-funded plan and I have been asked to provide a certificate of creditable coverage; if I am enrolling in the Kaiser plan, there is no pre-existing condition exclusion limitation for new or continuing enrollments on the plan.

Employee Signature

Date

Employer Signature

Date

Peralta Community College District Required Documentation Matrix

The below matrix outlines the documentation options that you can submit to verify eligibility for each dependent enrolled with health coverage. Please note the following:

- Send photocopies only. **Do not send original documents.**
- Mark out any personal financial information such as income, account balances, payment amounts, and so on.
- Write the Employee's Name and ID Number on each document.
- Retain a copy of all documentation and completed forms for your records.

Spouse

Please provide the following document to verify Proof of Relationship and Joint Ownership.

- **First Page of Employee's or Spouse's Federal Tax Return**

Photocopy of the first page of the employee or spouse's 2011 tax return showing "Married Filing Jointly" or "Married Filing Separately." The spouse's name must be entered on the employee's tax form in the space provided after the "Married Filing Separately" status. *Note: This document satisfies both Proof of Relationship and Proof of Joint Ownership. Please mark out all financial information.*

If you are unable to provide Employee or Spouse's Federal Tax Return, please provide one document from each of the following columns to verify Proof of Relationship and Proof of Joint Ownership

Spouse or Domestic Partner

If unable to provide a Federal Tax Return, please provide one document from each column to verify Proof or Relationship and Proof of Joint Ownership. Visit website www.ftb.ca.gov/individuals/faq/dompart.shtml.

Proof of Relationship Documents	Proof of Joint Ownership Documents
<ul style="list-style-type: none"> • Certified Marriage Certificate or License Photocopy of certified marriage certificate with appropriate signature and stamp/seal showing on photocopy or legally valid marriage license from appropriate state or local government. 	<ul style="list-style-type: none"> • Home Ownership Photocopy of mortgage statement dated within the past 3 months showing both names as mortgage holders/tenants. <i>Note: Please mark out all financial information.</i>
<ul style="list-style-type: none"> • Immigration Paperwork Photocopy of immigration papers with appropriate signature and stamp/seal showing on photocopy that identifies employee/spouse relationship. 	<ul style="list-style-type: none"> • Joint Rental Property Photocopy of lease or rental agreement dated within the past 12 months showing both names as tenants. <i>Note: Please mark out all financial information.</i>
<ul style="list-style-type: none"> • Notarized Affidavit of Common Law Marriage In cases of state recognized common law marriage, a Notarized Affidavit of Common Law Marriage. • Notarized Affidavit of Domestic Partnership Notarized Affidavit of Domestic Partnership. 	<ul style="list-style-type: none"> • Home/Rental Insurance Photocopy of homeowner's insurance, renter's insurance, or property tax receipt dated within the past 12 months showing both names as mortgage holders/tenants. <i>Note: Please mark out all financial information.</i> • Bank Statement Photocopy of joint bank account statement dated within the past 3 months showing both names as account holders. <i>Note: Please mark out all financial information.</i>

Spouse or Domestic Partner – continued

Proof of Relationship Documents	Proof of Joint Ownership Documents
<ul style="list-style-type: none"> Registration of Domestic Partnership Photocopy of certificate of registration as the employee’s domestic partner, if living in a city, county, state, or municipality providing for registration as domestic partner. 	<ul style="list-style-type: none"> Credit Card Statement Photocopy of credit card statement dated within the past 3 months showing both names as card holders. <i>Note: Please mark out all financial information.</i>
	<ul style="list-style-type: none"> Automobile Statement Photocopy of automobile title or registration dated within the past 12 months listing both names as co-owners.
	<ul style="list-style-type: none"> Loan Statement Photocopy of a loan agreement dated within the past 12 months showing both names as co-borrowers. <i>Note: Please mark out all financial information</i>
	<ul style="list-style-type: none"> Miscellaneous Bills Photocopy of two different types of current bills dated within the past 3 months showing one of the spouse’s names on each bill and the same common mailing address, e.g. telephone bill, electric bill, cable bill. <i>Note: Please mark out all financial information.</i>
	<ul style="list-style-type: none"> Beneficiary Statement Photocopy of designation as the primary beneficiary for life insurance or retirement benefits. <i>Note: Please mark out all financial information.</i>
	<ul style="list-style-type: none"> Driver’s License Photocopy of the employee’s and spouse’s driver’s licenses listing a common address.

Natural Child, Adopted Child, Step Child, Child of Domestic Partner, Dependent Child by Custody, Court Order, or Guardianship

Please provide **one** document for each child to verify Proof of Relationship .

- **Federal Tax Return**
Photocopy of the first page of the employee's, spouses, or domestic partner's 2010– 2011 Federal Tax return showing the child listed as an eligible dependent.
- **Court Certified Divorce Decree**
Photocopy of certified Divorce Decree with appropriate signature and stamp/seal showing on photocopy that documents required child health coverage.
- **Certified Legal Guardianship**
Photocopy of certified court ordered legal guardianship document with appropriate signature and stamp/seal showing on photocopy that documents required child health coverage.
- **Ordered Health Coverage**
Photocopy of Qualified Medical Child Support Order (QMCSO).
- **Court Ordered Health Coverage**
Photocopy of National Medical Support Notice (NMSN).
- **Court Ordered Health Coverage**
Photocopy of court document with appropriate signature ordering child health coverage.
- **Certified Birth Certificate**
Photocopy of certified birth certificate with appropriate signature and stamp/seal showing on photocopy that identifies the parent/child relationship with the employee, spouse, or domestic partner
- **Hospital Verification of Birth (Less than 6 months old)**
For children under 6 months old, photocopy of hospital verification of birth that identifies the employee, spouse, or domestic partner as the child's parent
- **Certified Adoption Certificate**
Photocopy of certified court approved adoption document with appropriate signature and stamp/seal showing on photocopy that identifies the employee, spouse, or domestic partner as the child's parent
- **Adoption Agreement**
Photocopy of placement letter/agreement from court or adoption agency that identifies the employee, spouse, or domestic partner as the child's parent
- **Report of Birth Abroad**
Photocopy of report of birth abroad of a citizen of the United States (issued by the State Department with appropriate signature and stamp/seal showing on photocopy) that identifies the employee, spouse, or domestic partner parent/child relationship
- **Immigration Paperwork**
Photocopy of immigration papers with appropriate signature and stamp/seal showing on the photocopy that identifies the parent/child relationship with the employee, spouse, or domestic partner

Disabled Adult Child

For disabled dependent children, you must also provide one of the following:

- Photocopy of Social Security disability award letter
- Photocopy of current Social Security disability payment
- Photocopy of signed physician Health Care Statement for Disabled Dependents certifying that the dependent is incapable of self-sustaining employment and dependent upon the employee, spouse, or domestic partner due to a mental and/or physical disability. To request a blank Health Care Statement for Disabled Dependents, contact PSW Benefit Resources at 1-877-866-2623 or technicalservices@pswbenefits.com



PERALTA BENEFITS – EVERYONE

Published by the PCCD Benefits Office

FAQ - Benefits and What to Expect After Enrollment

When will my coverage become effective?

If you are a new employee or have had a HIPAA qualifying event your coverage will become effective the first day of the month following your date of hire or the first day of the month following your qualifying event. If you are a current employee who has changed benefit options during open enrollment, your effective date will be September 1st.

When will I receive my ID card?

You must download your Delta Dental ID card from the Delta Dental website. Your Kaiser, Self Funded plan, and United Health Care Dental ID card will be issued within 7 to 10 business days from when Peralta processes your form.

How do I independently verify my enrollment and coverage?

To verify your enrollment and applicable coverage for you and your eligible dependents

- call the insurance carrier
- visit the website of the carrier you have selected

Refer to the *EMPLOYEE BENEFITS with your enrollment packet from the PCCD Benefits Office.*



What is an HMO? (Kaiser)

A health maintenance organization (HMO) is a type of managed care organization (MCO) that provides a form of health care coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract. Unlike traditional indemnity insurance, an HMO covers only care rendered by those doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers.



What is a PPO? (Self Funded)

A PPO is a group of hospitals and physicians that contract on a fee-for-service basis with insurance companies to provide comprehensive medical service. If you have a PPO, your out-of-pocket costs may be lower in a PPO than in a non-PPO plan.

What is a Deductible?

A deductible is the amount of money you or your dependents must pay toward a health claim before your organization's health plan makes any payments for health care services rendered. For example, a plan participant with a \$100 deductible would be required to pay the first \$100, in total, of any claims during a plan year.

What is Coinsurance?

Coinsurance is a provision in your health plan that describes the percentage of a medical bill that you must pay and that which the health plan must pay.

What is Out-Of-Pocket Maximum?

The maximum amount (deductible and coinsurance) that an insured will have to pay for covered expenses under a plan. Once the out of pocket maximum is reached the plan will cover eligible expenses at 100%.

What is an Explanation of Benefits (EOB)?

An EOB is a description your insurance carrier sends to you explaining the health care benefits that you received and the services for which your health care provider has requested payment.

What is a Pre-Existing Condition?

A pre-existing condition is a physical or mental condition that existed prior to being covered on a health benefit plan. Some insurance policies and health plans exclude coverage for pre-existing conditions. For example, your health plan may not pay for treatment related to a pre-existing condition for one year. You should check with your insurance carrier to learn how your organization's health plan treats pre-existing conditions

What is Utilization Management (UM)?

UM is the process of reviewing the appropriateness and the quality of care provided to patients. UM may occur before (pre-certification), during (concurrent) or after (retrospective) medical services are rendered. For example, your health plan may require you to seek prior authorization from your utilization management company before admitting you to a hospital for non-emergency care. This would be an example of pre-certification. Your medical care provider and a medical professional at the UM company will discuss what is the best course of treatment for you before care is delivered. UM reduces unnecessary hospitalizations, treatment and costs.



CLAIMS

I have a problem with my claim, who do I call?

You should call the insurance carrier first. You will find the number on the back of your ID card. If they do not resolve your problem, then call PSW Benefit Resources at (877) 866-2623.

RESOURCES

Where can I find information about my benefits?

You can find information about your benefits on the internet by going to the Peralta Community College District Benefits Information Center (BIC).

www.peralta.pswbenefits.net

www.peraltaretirees.pswbenefits.net

PAYCHECK CONTRIBUTIONS

If there is a question regarding payroll medical, dental or flexible spending deductions, contact the Peralta Benefits Office at (510) 466-7229 or email: benefits@peralta.edu.