UNIVERSAL BENEFIT RE-ENROLLMENT FORM

ALL BENEFIT CHANGES MADE ON THIS ENROLLMENT FORM WILL BE EFFECTIVE 03/01/09 – 08/31/09

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

COMPLETE SECTIONS 1-8 AND RETURN TO THE BENEFITS OFFICE NO LATER THAN MONDAY, FEBRUARY 9, 2009

PERALTA COMMUNITY COLLEGE DISTRICT

1. EMPLOYEE INFORMATION *(Please Print)*

Employee Name *(last name, first name, middle initial)*	**SHADED AREA FOR OFFICE USE ONLY:**	
Employee Address (street, city, state, zip code)	EFFECTIVE DATE:	March 1, 2009
	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 Eligibility 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 Eligibility 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**_____

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

4. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? Yes No If yes, who?_____
2. 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)
			☐Health ☐Other:_____		
			☐Health ☐Other:_____		
			☐ Health ☐Other:_____		
			☐ Health ☐Other:_____		
			☐ Health ☐Other:_____		

5. KAISER ENROLLEES MUST READ AND SIGN:

Kaiser Foundation Health Plan Arbitration Agreement: ☐ Check if NOT enrolling in Kaiser

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. CORESOURCE ENROLLEES MUST READ AND SIGN:

☐ Check if NOT enrolling in Coresource

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 CoreSource 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 CoreSource are giving up the right to have any dispute decided in a court of law before a jury. CoreSource 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.

_____ _____

EMPLOYEE SIGNATURE **DATE**

7. 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 address change**
2. **change to my marital status resulting in adding or deleting a spouse or domestic partner**
3. **change to my eligible dependents status adding a newborn**

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.

EMPLOYEE SIGNATURE _____ **DATE** _____

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

50/50 Plan:

Medical Premium $_____ ÷ 2 = $_____ X 6 = $_____ ÷ 3 = $_____

Dental Premium $_____ X 6 = $_____ ÷ 3 = $_____

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: $_____

100% Plan:

Medical Premium $_____ X 6 = $_____ ÷ 3 = $_____

Dental Premium $_____ X 6 = $_____ ÷ 3 = $_____

TOTAL MEDICAL AND DENTAL PREMIUM PER PAY PERIOD: $_____