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)*	**SHADED AREA FOR OFFICE USE ONLY:**	
Employee Address (street, city, state, zip code)	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**_____

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: $_____

Peralta Community College
Eligibility Affidavit
50% / 50% and 100% Plan
Fall 2008

RETURN THIS FORM TO THE BENEFITS OFFICE NO LATER THAN MONDAY, SEPTEMBER 15, 2008. INCOMPLETE OR FORMS RECEIVED AFTER THIS DATE WILL NOT BE PROCESSED AND WILL BE RETURNED TO YOU.

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 _____ Zip Code _____

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 Instructor Assignment roster 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 an Adjunct Universal Enrollment Form.

Coverage 50% / 50% Plan	Your 50% / 50% Monthly Share Employee pays 3 months, PCCD pays 3 months Kaiser	Your 50% /50% Monthly Share Employee pays 3 months, PCCD pays 3 months CoreSource
Single	$223.00	$262.54
Two Party	$446.01	$586.59
Three Party	$631.10	$881.25

Coverage 100% Plan	Your 100% Monthly Share Employee makes 3 installments for 6 months of coverage Kaiser	Your 100% Monthly Share Employee makes 3 installments for 6 months of coverage CoreSource
Single	$446.01	$525.09
Two Party	$892.02	$1,173.19
Three Party	$1,262.20	$1,762.51

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	$60.67	$23.84
Two Party	$103.14	$38.15
Three Party	$157.75	$58.41

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.

Section D: Payroll Deduction Authorization

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 October, November and December 2008.

_____ **(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 October, November and December 2008. 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: Adjunct Faculty Benefit Checklist & Universal Enrollment Form Checklist are attached to this Affidavit. _____ (initial here)

Adjunct or Part time Faculty Benefit Checklist
Fall 2008

This form MUST accompany all enrollment forms. Visit our website for valuable enrollment literature and information at www.peralta.edu

Information Received	Initial here if you need hard copies of literature	Date Provided to Employee
Benefit Summaries and Plan Specific Documents		
1. CoreSource Medical PPO Plan		
2. Kaiser Medical HMO and Vision Plan		
3. Plan Highlights		
4. CoreSource Pre-Existing Condition Affidavit		
5. CoreSource Summary Plan Description		
6. Caremark Prescription Drug Benefits (CoreSource)		
7. Caremark Mail Order Prescription Form (CoreSource)		
8. Spectera Vision Care Benefits		
9. Delta Dental PPO and United HealthCare DMO Dental Comparison		
10. Delta Dental PPO Overview		
11. United HealthCare Dental Material (summary, provider list)		
12. Flexible Benefit Medical & Dependent Care Reimbursement Plan Overview (deductions occur in October, November and December 2008)		
13. Transportation & Parking Flexible Benefit Plan Overview		
14. Prepaid Legal Plan Overview (Voluntary Plan)		
15. Retirement Plan Highlights (plan 403(b))		
16. Disability Income / 24 Hour Family Accident Insurance / Term Life Insurance—JC Insurance		
THE FOLLOWING ITEMS MUST BE RETURNED WITHIN 30 DAYS FROM DATE OF HIRE, START DATE, OR QUALIFYING EVENT, WHICHEVER OCCURS LATER		
17. Universal Benefit Enrollment Form		
18. Application of Pre-Existing Condition Exclusion		
19.Eligiblity Affidavit		
20. Flexible Benefits Plan Enrollment		
21. Pre-Tax Commuting Enrollment		
THE FOLLOWING FORMS CAN BE RETURNED AT ANY TIME		
22. Pre-Paid Legal Enrollment Form		
23. Salary Reduction Agreement Form		

Waiver and Acknowledgement

I have read and understand my options. If I enroll in a group insurance plan, I agree to notify the District within 30 days of a QUALIFYING EVENT. (A QUALIFYING EVENT occurs when there is a loss of other group coverage as defined by HIPAA). The employee is responsible for notifying the PCCD Office within 30 days of the loss of other group coverage in order to enroll in a PCCD insurance plan. If I do not enroll now, I understand that I may enroll at a later date subject to open enrollment provisions and pre-existing condition requirements. I also understand that my premiums are pre-tax and I will notify the District if I prefer after tax deductions. I understand that this enrollment form is applicable to the Fall of 2008 semester only and that I MUST re-enroll to re-establish eligibility each semester.

_____ (Signature) _____ (Date)

Notification of Pre-Existing Condition Limitation

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 October of each year for all other employees.

The plan 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.

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

Jennifer Seibert
District Benefits Coordinator
Peralta Community College District
333 East 8th Street,
Oakland, CA 94606
Phone number: 510 587.7868
Email: jseibert@peralta.edu

Application of Pre-Existing Condition Exclusion

Submit this form with the Universal Enrollment Form

Employee and/or Dependent Name(s): _____

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.

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:

Jennifer Seibert
District Benefits Coordinator
Peralta Community College District
333 East 8th Street,
Oakland, CA 94606
Phone number: 510 587-7868
Email: jseibert@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 Human Resources for assistance in resubmitting your claim.*

I understand that I am enrolling in the self-funded plan and I have been asked to provide a certificate of creditable coverage.

_____ _____
Employee Signature **Date**

_____ _____
Employer Signature **Date**