UNIVERSAL BENEFIT ENROLLMENT FORM

SUBMIT THIS FORM WITHIN 30 DAYS OF QUALIFYING EVENT

(hire, birth of child, marriage, divorce, etc.)

ALLOW FIVE (5) DAYS FOR PCCD PROCESSING & FIVE (5) DAYS FOR VENDOR PROCESSING. CHANGES ARE EFFECTIVE THE FIRST OF THE FOLLOWING MONTH.

PERALTA COMMUNITY COLLEGE DISTRICT
333 East 8th Street
Oakland, CA 94606

Active employees:	**Review and/or complete sections 1 – 10 (5,8 or 9, if applicable)**
Retirees:	**Complete sections 1, 2, 3, (4, 8 or 9 if applicable)**
Surviving spouses and/or COBRA participants:	**Complete sections 1, 2, 4, (8 or 9 if applicable)**
(INCOMPLETE FORMS WILL BE RETURNED)	

⇨ ***Start Here*** **EMPLOYMENT STATUS/AFFILIATION WITH PCCD**

☐**Initial Enrollment** ☐**Address Change** ☐**Change of Medical or Dental Plan** ☐**Change of Dependent or Beneficiary** ☐**Change from Active to Retiree**

1. EMPLOYEE INFORMATION ***please print (all covered employees/retirees/surviving spouses/COBRA participants)***

Employee Name ***(last, first, middle)***	**SHADED AREA FOR OFFICE USE ONLY:**	
Employee Address ***(street, city, state, zip)***	**EFFECTIVE DATE:**	
	MEDICAL GROUP/DIVISION #:	
	DENTAL GROUP/DIVISION #:	
	FORM REVIEWED & APPROVED BY:	
	BENEFIT PLAN PARTICIPATION:	**PRB/PFF/RET**
	DATE REVIEWED & APPROVED:	

Home Phone:	**Alternate Phone:**	**Email Address:**

Work Location	**Union Affiliation**	**Hours/Week:**	**Social Security #**	**Date of Birth**	**Date of Hire / /**	**Year of Retirement (if applicable)**

MALE☐ **FEMALE**☐ **MARITAL STATUS:** ☐**Single** ☐**Married** (Date:_____) ☐**Divorced** (Date:_____)

☐**Surviving spouse of a retiree: Name of retiree:**_____**Date of retiree death:**_____

INDIVIDUALS COVERED *please print (all covered employees/retirees/surviving spouses/COBRA participants)*

Add **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	**Totally Disabled?**	**Legal Dependent?**
						☐Yes ☐No	☐Yes ☐No
						☐Yes ☐No	☐Yes ☐No
						☐Yes ☐No	☐Yes ☐No
						☐Yes ☐No	☐Yes ☐No

2. BENEFIT PLANS

•MEDICAL/ VISION	*Choose one*:	☐ Kaiser Permanente HMO / Traditional Plan ☐ Kaiser Senior Advantage HMO/Vision/Dental Plan ☐ Coresource PPO Plan (includes participation in the Anthem Blue Cross Network) ☐ Waive medical/vision coverage- Complete Cash-in-lieu Form (active employees only)	*Choose one:*	(1)☐ Employee only (2)☐ Employee + 1 dep (3)☐ Employee + family
•DENTAL	*Choose one:(Must either be an active employee or currently on COBRA)*	☐ Delta PPO Dental Plan ☐ UHC DMO (formerly Pacific Union Dental) **MUST designate DMO Provider* ☐ Waive dental coverage Complete Cash-in-lieu Form (active employees only)	*Choose one:* DMO Provider ID# (obtain from member services) 800-999-3367	(1)☐ Employee only (2)☐ Employee + 1 dep (3)☐ Employee + family

EMPLOYEE NAME_____

3. OTHER HEALTH INSURANCE

1. Is anyone listed eligible for Medicare? ☐Yes ☐No If Yes, Medicare #_____
   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:_____		

4. THE HARTFORD LIFE/AD&D (all active employees and retired employees to age 66)

Basic Life Insurance (Employer pays Premium) ☒Life/AD&D Insurance ($1^{1/2}$ times base earnings to a maximum of $100,000)

Primary Beneficiary's	Last Name	First	MI		%
Street Address		City		State	Zip
Contingent Beneficiary's Last Name		First	MI		%
Street Address		City		State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. **If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.**

_____ _____

EMPLOYEE SIGNATURE **DATE**

5. CIGNA VOLUNTARY LIFE INSURANCE (active employees only)

( ) Check here if you would like more information sent to your home address regarding Voluntary Employee or Dependent Life

Note: For late enrollees, all coverage amounts are subject to Evidence of Good Health. You may apply for additional insurance from $10,000 or more for yourself or your eligible dependents.

6. THE HARTFORD LONG TERM DISABILITY (active employees only)

☒ **60% LTD Plan - Basic Income Replacement (employer pays premium)**

7. EMPLOYEE ASSISTANCE PROGRAM (active employees only)

☒ **Anthem Blue Cross Employee Assistance Plan (employer pays premium for active employees only)**

8. KAISER PERMANENTE ENROLLEES MUST READ AND SIGN:

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, relatives, 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 (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our 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**

EMPLOYEE NAME_____

9. CORESOURCE ENROLLEES MUST READ AND SIGN:

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.

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 District's self-funded plan administered by CoreSource 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

_____ _____

EMPLOYEE SIGNATURE **DATE**

10. All EMPLOYEES MUST READ AND SIGN: I agree to notify the District in writing within 30 days of the following to preserve benefit enrollment.

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 be subject to imputed income per tax regulations**

_____ _____

EMPLOYEE SIGNATURE **DATE**