UNIVERSAL BENEFIT ENROLLMENT FORM

SUBMIT THIS FORM WITHIN 30 DAYS OF QUALIFYING EVENT
(date of hire, birth of child, marriage, divorce, etc.)
ALLOW 10 DAYS FOR PCCD & VENDOR PROCESSING. CHANGES ARE EFFECTIVE THE FIRST DAY OF THE FOLLOWING MONTH (EXCEPTION BIRTH AND ADOPTION – EFFECTIVE ON DATE OF BIRTH OR ADOPTION).

Date:_____

Retirees: Complete sections 1, 2, 3, 4, 5, 6 & 7 (as applicable)
Surviving spouses and/or COBRA participants: Complete sections 1, 2, 3, 5, 6, & 7 (as applicable)

(INCOMPLETE FORMS WILL BE RETURNED)

PERALTA COMMUNITY COLLEGE DISTRICT
BENEFITS OFFICE
333 East 8th Street

Start Here

EMPLOYMENT STATUS/AFFILIATION WITH PCCD

☐ **Initial Enrollment** ☐ **Address Change** ☐ **Change of Medical** ☐ **Change of Dental Plan** ☐ **Change of Dependent**
☐ **Change of Life Insurance (VOYA)** ☐ **Change from Active to Retiree** ☐ **Open Enrollment Change**

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

Employee Name ***(last, first, middle)***	**SHADED AREA FOR OFFICE USE ONLY** **EID #:**_____	
	EFFECTIVE DATE:	
Employee Address ***(street, city, state, zip)***	**MEDICAL GROUP/DIVISION #:**	**65**_____**; 4138**_____
	DENTAL GROUP/DIVISION #:	**938**_____
	FORM REVIEWED & APPROVED BY:	
Gender: ☐MALE ☐FEMALE	**BENEFIT PLAN PARTICIPATION:**	**PRB/PFF/RET**

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

District Affiliation	**Work Location**	**Social Security #**	**Hours/Week**	**Date of Birth**	**Year of Retirement (if applicable)**
					☐On or before 6/30/2004 ☐Between 7/1/2004 & 6/30/2012 ☐On or after 7/1/2012

MARITAL STATUS: ☐Single ☐ Widow ☐ Separated (Date:_____) **☐Married** (Date:_____)
☐ Divorced (Date:_____) **☐Domestic Partner** (Date:_____)
☐Surviving spouse of a retiree: Name of retiree:_____**Date of retiree death:**_____

INDIVIDUALS COVERED *please print (retirees/surviving spouses/COBRA participants).*
PLEASE RESTATE ALL DEPENDENTS TO BE COVERED

Change Drop	Last Name, First Name	Social Security Number	Date of Birth	Sex	**Relationship:** Spouse; Registered Domestic partner; Non-Registered 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 joint ownership ▪ Other ▪ Affidavit for overage dep.
						☐Yes ☐No	
						☐Yes ☐No	
						☐Yes ☐No	
						☐Yes ☐No	

If dropping / adding dependents, please specify reason:_____

2. BENEFIT PLANS

•MEDICAL	*Choose one:* (*premiums carry forward into retirement)	☐ Kaiser Permanente HMO – Senior Advantage participants must complete a different form ☐ Peralta "*Traditional" PPO Plan (In- and out-of-network benefits - includes participation in the Anthem Blue Cross Network) ☐ Peralta "Lite" PPO Plan (in-network benefits only - includes participation in the Anthem Blue Cross Network)	*Choose one:*	(1)☐ Single (2)☐ Single + 1 dep (3)☐ Single + family • Refer to Peralta Community College District Required Documentation Matrix
•DENTAL	*Choose one:* ***COVERAGE AVAILABLE FOR COBRA PARTICIPANTS ONLY***	*This section does not apply to retirees.* ☐ Delta Dental plus Premier Dental Plan ☐ UHC DMO (formerly Pacific Union Dental) **MUST* *designate DMO Provider*	*Choose one:*	(1)☐ Single (2)☐ Single + 1 dep (3)☐ Single + family • Enrollment for dependents is incomplete without documentation. Incomplete forms are not processed.
				DMO Provider ID# (obtain from member services) 800-999-3367

3. 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)
			☐Health ☐Other:_____		
			☐Health ☐Other:_____		

4. RELIASTAR LIFE INSURANCE COMPANY LIFE/AD&D (all 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 #1 Last Name First MI ☐ % %

Street Address City State Zip

Primary Beneficiary #2 Last Name First MI ☐ % %

Street Address City State Zip

Contingent Beneficiary #1 Last Name First MI ☐ %

Street Address City State Zip

Contingent Beneficiary #2 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 two Primary or Contingent Beneficiaries, please attach a separate sheet of paper.**

_____ ☐ Check here if adding an additional page, sign and date the additional page. _____

RETIREE SIGNATURE **DATE**

5. 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 or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

In my absence, you are authorized to contact the following regarding my Peralta benefits:

First Name: **Last Name:** **Contact Telephone Number:**

6. PERALTA PPO PLAN 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 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 day 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 part time hourly employees and in May of each year for all other employees.

EMPLOYEE SIGNATURE _____ **DATE** _____

In my absence, you are authorized to contact the following regarding my Peralta benefits:

First Name: **Last Name:** **Contact Telephone Number:**

7. DELTA DENTAL PLUS PREMIER DENTAL PLAN ENROLLEES MUST READ AND SIGN:

I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

EMPLOYEE SIGNATURE _____ **DATE** _____

In my absence, you are authorized to contact the following regarding my Peralta benefits:

First Name: **Last Name:** **Contact Telephone Number:**

8. UHC DMO DENTAL PLAN ENROLLEES MUST READ AND SIGN:

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless it is contained in a written statement signed by me, and a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

FRAUD WARNING NOTICE:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

EMPLOYEE SIGNATURE _____ **DATE** _____

In my absence, you are authorized to contact the following regarding my Peralta benefits:

First Name: **Last Name:** **Contact Telephone Number:**

9. TERMS AND AGREEMENT (RETIREES/SURVIVING SPOUSES, EMPLOYEES AND COBRA PARTICIPANTS 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. 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.
6. If adding a spouse, then I am exempt from imputed income at the State and Federal levels.
7. Failure to notify the District of change in dependent status may result in PCCD to recoup claims costs.
8. Enrollment subject to post enrollment audit
9. I agree to pay premiums based on my plan election. I understand and have reviewed the premiums associated with my plan elections.

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.

RETIREE/SURVING SPOUSE/COBRA/EMPPLOYEE PARTICIPANT SIGNATURE _____ **DATE** _____

In my absence, you are authorized to contact the following regarding my Peralta benefits:

First Name: **Last Name:** **Contact Telephone Number:**