UNIVERSAL BENEFIT ENROLLMENT FORM

SUBMIT THIS FORM WITHIN 31 DAYS OF QUALIFYING EVENT
(date of hire, birth of child, marriage, divorce, etc.)
ALLOW 10 DAYS FOR COUNTY & VENDOR PROCESSING. CHANGES ARE EFFECTIVE THE FIRST DAY OF THE FOLLOWING MONTH (EXCEPTION BIRTH AND ADOPTION – EFFECTIVE ON DATE OF BIRTH OR ADOPTION).

Date:_____

(INCOMPLETE FORMS WILL BE RETURNED)

San Benito County
Human Resources
Department
481 4th Street
Hollister, CA 95023

☐ **Initial Enrollment** ☐ **Open Enrollment Change** ☐ **Qualifying Life Event Change (please specify):** _____

1. EMPLOYEE INFORMATION *please print*

Employee Name ***(last, first, middle)***	**SHADED AREA FOR OFFICE USE ONLY** **EID #:**_____
	EFFECTIVE DATE:
Employee Address ***(street, city, state, zip)***	**MEDICAL GROUP/DIVISION #:**
	DENTAL GROUP/DIVISION #:
	MES GROUP/DIVISION#
	FORM REVIEWED & APPROVED BY:
Gender: ☐**MALE** ☐**FEMALE**	

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

Work Location	**Social Security #**	**Hours/Week**	**Date of Birth**

MARITAL STATUS: ☐**Single** ☐ **Widow** ☐ **Separated** (Date:_____) ☐**Married** (Date:_____)
☐ **Divorced** (Date:_____) ☐**Domestic Partner** (Date:_____)

INDIVIDUALS COVERED *please print*
PLEASE STATE ALL DEPENDENTS TO BE COVERED; ATTACH ADDITIONAL PAGE IF NECESSARY

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?	Enroll in	Type of Document Attached:
						☐Yes ☐No	☐ Medical ☐ Dental ☐ Vision	
						☐Yes ☐No	☐ Medical ☐ Dental ☐ Vision	
						☐Yes ☐No	☐ Medical ☐ Dental ☐ Vision	
						☐Yes ☐No	☐ Medical ☐ Dental ☐ Vision	

➡ **If dropping / adding dependents, please specify reason:**_____

2. BENEFIT PLANS

MEDICAL	*Choose one*:	☐ Kaiser Permanente HMO ☐ EIA Anthem Choice PPO Plan ☐ EIA Anthem Safety PPO (available only to Safety members) ☐ EIA Anthem HDHP 1300 / 2600 ☐ Waive Coverage* *Separate County waiver form must be completed and returned to Human Resources	*Choose one:*	(1)☐ Single (2)☐ Single + 1 dep (3)☐ Single + family
DENTAL	*Choose:*	☐ Delta Dental PPO Plan ☐ Waive Coverage	*Choose one:*	(1)☐ Single (2)☐ Single + 1 dep (3)☐ Single + family
VISION	*Choose:*	☐ MES Vision ☐ Waive Coverage	Choose one:	(1)☐ Single (2)☐ Single + 1 dep (3)☐ Single + family

3. LINCOLN FINANCIAL LIFE/AD&D

The County of San Benito provides both an employer paid life insurance benefit as well as a voluntary, employee paid life insurance benefit. Employees must complete the separate Lincoln Financial enrollment form to participate.

4. WAGEWORKS FSA AND HSA

Flexible Spending Accounts FSA (must complete Wageworks enrollment form)

☐ **HEALTH CARE FSA ELECTION** (up to $2,550): ☐ **DEPENDENT CARE FSA ELECTION (**up to $5,000):

☐ **LIMITED HEALTH CARE FSA ELECTION *MUST BE A HDHP PARTICIPANT*** (up to $2,550):

Health Savings Account HSA (must complete Wageworks enrollment and HSA application form) – HDHP PARTICIPANTS ONLY

☐ **HEALTH SAVINGS ACCOUNT ELECTION** (up to $3,400 for self-only coverage / $6,750 for family coverage):

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**

6. ANTHEM 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.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- **The date eligibility for COBRA Continuation Coverage ends, or**
- **The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or**
- **The date your employer discontinues coverage with Anthem Blue Cross, or**
- **The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or**
- **The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.**

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end. Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

EMPLOYEE SIGNATURE _____ **DATE** _____

7. DELTA DENTAL PPO AND MES VISION 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**

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

In exchange for my enrollment, I agree to notify the County in writing within 31 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 County of change in dependent status may result in San Benito County 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.

EMPLOYEE SIGNATURE **DATE**