2009 BENEFIT ENROLLMENT FORM

Name:

Dept:
Employee ID:
Event Class:

Bargaining Unit: L
Benefit Program: **P06**
Effective Date:

This statement lists your benefit options and their associated pay period costs.
Use this worksheet to select your insurance coverage for 2009. Please note that these choices will remain in effect throughout 2009 unless you experience a change in family status. If a change occurs, you must submit proof within 30 days.
Put the option code (in parentheses) and the amount selected in the space provided on the right.
Return your completed enrollment form to the Department Payroll/Personnel Clerk. If you do not return the enrollment form, your coverage will remain the same. You must complete this form if you are re-enrolling in the Flexible Spending Acct.
Please keep a copy of this form for your records.
Proof of other coverage and waiver form required if waiving medical coverage.

MEDICAL COVERAGE – 100% COUNTY PAID AT LOWEST COST LEVEL

Refer to the table below to get the value of your credit for medical coverage.
This value is used in computing the additional cost of the medical coverage if you select a higher priced plan.

If you select the lowest priced medical plan, you pay nothing.

CREDIT- MEDICAL COVERAGE

	Employee Only	Employee + 1	Employee + Family	Credit
Medical – Credit by Coverage Level	$ 251.67	$ 503.33	$ 679.49	
Waive Credit	$ 23.75			Semi-monthly credit_____

YOUR OPTIONS

PRICE AND OPTION CODES

	Employee Only	Employee + 1	Employee + Family	Option Selected & Cost
Medical Plans				
Health Plan of San Joaquin	$ 251.67 (1)	$ 503.33 (2)	$ 679.49 (3)	
Kaiser	$ 273.78 (4)	$ 547.56 (5)	$ 739.20 (6)	
PacifiCare HMO	$ 274.91 (7)	$ 549.82 (8)	$ 742.25 (9)	
PacifiCare POS	$ 366.30 (10)	$ 772.80 (11)	$ 1106.09 (12)	Option Code _____
Waive	$ 0.00 (W)			Semi-monthly cost _____

Medical Plan Cost $ _____

Minus Credit by Coverage Level $ _____

Total This is the semi-monthly amount that will be deducted from your paycheck before taxes. $ _____
(If you are Waiving your coverage, you will have a semi-monthly credit.)

FLEXIBLE BENEFIT PROGRAM (Does not include Medical)

The County has provided a flexible credit that totals **$62.50** semi-monthly to be used for Dental and Vision only.

YOUR OPTIONS	**SEMI-MONTHLY PREMIUMS AND OPTION CODES**			
	Employee Only	Employee + 1	Employee + Family	Waive / Option Selected & Costs
If a dental plan is selected, you must also select a vision plan.				
Dental				
*Dental Plan	$ 16.34 (1)	$ 29.67 (2)	$ 48.69 (3)	Option Code _____
Waive	$ 0.00 (W)			Pay period cost_____
If a vision plan is selected, you must also select a dental plan.				
Vision				
Vision Plan	$ 4.93 (1)	$ 10.11 (2)	$ 13.81 (3)	Option Code _____
Waive	$ 0.00 (W)			Pay period cost_____

Total Pay Period Cost	$ _____
Minus Flexible Credit per Pay Period	$ **62.50**
Flexible Excess Remaining (This amount will be reflected on your paycheck as earnings.)	$ _____

*Note: The Dental Premiums shown above are only a portion of what the County is actually paying. The full premium amounts are for your information only and are as follows: EE- $18.50, EE+1- $37.00, Family- $63.40.

Life and AD&D	Coverage Amount
Basic Life AD&D- $20,000 Resident Physicians	$ 20,000

The County will continue to provide Basic Life Insurance Coverage at no cost to the employee.

When enrolling in or increasing Supplemental Life, an Evidence of Insurability Form must be completed.

Supplemental Life	Coverage Amount	& Premiums	
Supplemental Life - $ 20,000	$ 20,000	$ 2.25 (1)	Option Code _____
Supplemental Life - $ 30,000	$ 30,000	$ 3.38 (2)	Premium _____
Supplemental Life - $ 50,000	$ 50,000	$ 5.63 (3)	
Supplemental Life - $100,000	$ 100,000	$ 11.25 (4)	
Supplemental Life - $150,000	$ 150,000	$ 16.88 (5)	
Supplemental Life - $200,000	$ 200,000	$ 22.50 (6)	
Supplemental Life - $250,000	$ 250,000	$ 28.13 (7)	
Supplemental Life - $300,000	$ 300,000	$ 33.75 (8)	
Waive		$ 0.00 (W)	

***The Supplemental Life Premium represents the semi-monthly cost and administrative fee that will be deducted Before-Tax from your paycheck.**

FLEXIBLE SPENDING ACCOUNTS (You must re-enroll every plan year.)

YOUR OPTIONS	**PRICE AND OPTION CODES**	Option Selected & Option Code:

Health Care
Medical Care Reimbursement Plan (1)

Minimum Annual Contribution: $ 0.00
Maximum Annual Contribution: $ 2500.00

Annual Pledge $ _____ Option Code _____

(Annual-Pledge / Pay-Pds-Remaining)
(_____ / _____) = Pay period cost_____

Dependent Care
Dependent Care Reimbursement Plan (1)

Minimum Annual Contribution: $ 0.00
Maximum Annual Contribution: $ 5000.00

Annual Pledge $ _____ Option Code _____

(Annual-Pledge / Pay-Pds-Remaining)
(_____ / _____) = Pay period cost_____

Total Cost per Pay Period $ _____

Plus Administrative Fee per Pay Period $ **2.77**

Total $ _____

The Total represents the pay period amount that will be deducted from your bi-weekly pay check.

To the best of my knowledge the information provided on this form is true and correct. I request the coverage provided and agree to the required deduction (if any) from my wages.

I understand that under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), I can continue medical, dental and vision insurance benefits for myself and if applicable, my dependents, upon termination of my employment with Stanislaus County. In order to qualify, I know that I, and/or my dependents, cannot be covered by another group health plan through another source, unless there is a pre-existing condition clause that would allow eligibility and coverage for the condition only. Premium payment obligation begins when County sponsored group coverage ends. I also understand that by signing below, I am only acknowledging notification of my continuation rights under COBRA.

Signature: _____ **Date: _____**