Stanislaus County Benefit Enrollment Form- 2016

Please complete this universal benefit enrollment form in its entirety when enrolling or making changes to your Benefits. Refer to your Benefit Guide for detailed information on your benefit options. Check the box next to the option of your choice. Enter all dependent/beneficiary information if necessary. If there is a Life Event change, you must submit this completed form and backup documentation within 30 days of the qualifying event. **Marriage and/or Birth Certificates are required when enrolling a new Dependent in a Health Plan.**

1. Employee General Information

☐ New Hire	Hire Date: / /	☐ Change/Type _____	Change Date: / /	Dept:	Emplid:

Last Name:	First Name:	New Last Name: (If applicable)	MI

Address:	City:	State:	Zip Code:

Phone# Home: Work:	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Date of Birth: / /
Social Security # – –			Home Email:

2. Medical Plan Options and Semi-Monthly Employee Pre-Tax Share of Premiums

Stanislaus County Partners in Health and Anthem Blue Cross		**Waiver of Medical Plan** If you qualify for the Medical Plan Reimbursement Program- refer to the Medical Reimbursement Form for guidelines. Attach the completed reimbursement form to this benefit enrollment.
HDHP ☐ Empl Only - $15.29 ☐ Empl + 1 - $30.58 ☐ Family - $41.28	**EPO** ☐ Empl Only - $73.12 ☐ Empl + 1 - $146.24 ☐ Family - $197.43	☐ **Waive Medical Coverage** – I understand that I am freely waiving the right to participate in this benefit. Further, I understand the County shall provide compensation in the manner approved by the Board of Supervisors for employees in my classification. I have attached a **copy of my proof of other coverage**. I understand there are restrictions on when I would be allowed to re-enroll. ☐ My spouse/parent works for the County and has covered me as a dependent. Specify spouse/parent's Name/Dept.- _____

3. Coordination of Benefits (Employee cannot have dual medical coverage if enrolling in a County High Deductible Plan)

Do you currently have other medical insurance coverage? ☐ Yes ☐ No Will you be keeping your other coverage? ☐ Yes ☐ No

Name of Other Insurance Carrier/Medical Plan	Medical ID Number	Employer

4. Dental / Vision Plan Options and Semi-Monthly Employee Pre-Tax Share of Premiums

Delta Dental Core Plan	Delta Dental Buy-Up Plan	Vision Service Plan
☐ Employee Only - $3.58	☐ Employee Only - $13.23	☐ Employee Only - $.83
☐ Employee + 1 - $7.15	☐ Employee + 1 - $26.45	☐ Employee + 1 - $.1.61
☐ Family - $12.25	☐ Family - $45.32	☐ Family - $2.27
☐ Waive Dental Coverage		☐ Waive Vision Coverage

5. Basic and Supplemental Life AD&D Insurance with Semi-Monthly Employee After-Tax Share of Premiums

Basic Life Employee Only – No Cost to Employee

☐ $10,000 - All Full-Time Represented and Confidential Employees

Basic Life and AD&D Employee Only – No Cost to Employee

☐ $30,000 – All Full-Time Management and Dept Head Employees

☐ $50,000 – All Full-Time Attorneys

Voluntary Supplemental Life and AD&D - Employee

At time of hire you can elect supplemental life coverage up to the Guarantee Issue (GI) Limit without evidence of insurability. Anytime you elect an amount greater than the GI Limit, you will need to complete an Evidence of Insurability form subject to approval by ReliaStar Life. Refer to benefit guide for GI Limits.

☐ $20,000 + AD&D - $2.25 ☐ $30,000 + AD&D - $3.38 ☐ $50,000 + AD&D - $5.63 ☐ $100,000 + AD&D - $11.25

☐ $150,000 + AD&D - $16.88 ☐ $200,000 + AD&D - $22.50 ☐ $250,000 + AD&D - $28.13 ☐ $300,000 + AD&D - $33.75 ☐ Waive Supp. Life

☐ I selected an option greater than the Guarantee Issue limit. I have completed the Evidence of Insurability form and submitted to ReliaStar for underwriting approval. I understand I will not be charged a premium for any amount greater than the GI Limit until I receive approval from ReliaStar.

Voluntary Supplemental Life and AD&D – Spouse

Guarantee Issue- When spouse is first eligible. Employee must have the same or more supplemental life coverage. Marriage certification is required.

☐ $20,000 + AD&D - $2.25 ☐ $30,000 + AD&D - $3.38

Employee is the beneficiary of this life insurance policy.

Voluntary Supplemental Life – Dependent Child

Guarantee Issue- When child(ren) is first eligible. Employee must have the same or more supplemental life coverage. Dependent certification is required.

☐ $10,000 - $1.25 Premium covers all dependent children in family.

Employee is the beneficiary of this life insurance policy.

6. Dependent and/or Beneficiary Information for Health and Life Plans

List all dependent information and indicate coverage for medical, dental, vision. If different, list all beneficiaries for employee life insurance and indicate % of benefit and whether Primary/Contingent. Attach separate sheet for additional dependents/beneficiaries. **Marriage and/or birth certificates required for dependents enrolled in health plans.**

Last Name First Name	Social Security Number	Relation ship	Date of Birth	Sex	Add	Delete	Medical	Dental	Vision	Basic and Supplemental Life Beneficiary's		
										Basic %	Supp %	Primary/ Contingent
1.					☐	☐	☐	☐	☐			
2.					☐	☐	☐	☐	☐			
3.					☐	☐	☐	☐	☐			
4.					☐	☐	☐	☐	☐			
5.					☐	☐	☐	☐	☐			
6.					☐	☐	☐	☐	☐			

7. Accident Insurance with Semi-Monthly Employee After- Tax Share of Premiums

☐ Employee Only - $3.77 ☐ Employee + Child(ren) - $6.85
☐ Employee + Spouse - $6.25 ☐ Family - $9.33

Guarantee Issue when first eligible. You may elect coverage for your spouse up to age 70 and children up to age 26. Certification of dependent status is required.

8. Critical Illness Insurance with Semi-Monthly Employee After- Tax Share of Premiums

Guarantee Issue when first eligible. Employees must have the same or more coverage as spouse or child selection. The semi-monthly rates below are per thousand based on age of enrollment. Semi-monthly premium covers all children enrolled. Dependent certification required. Select individual coverage from options below.

Employee Rates – Issue Age

Rates are per $1,000	Semi-Monthly Rates
18-24	$0.39
25-29	$0.50
30-34	$0.60
35-39	$0.78
40-44	$1.10
45-49	$1.55
50-54	$2.07
55-59	$2.62
60-64	$3.36
65-69	$4.75
70+	$6.87

Spouse Rates – Issue Age

Rates are per $1,000	Semi-Monthly Rates
18-24	$0.64
25-29	$0.65
30-34	$0.78
35-39	$1.02
40-44	$1.47
45-49	$2.15
50-54	$3.04
55-59	$4.05
60-64	$5.20
65-69	$7.06
70+	$8.84

Children Rates

Rates are per Benefit Level	Semi-Monthly
$10,000	$4.76

Critical Illness Insurance – Employee

☐ $ 5,000 ☐ $15,000 ☐ $25,000
☐ $10,000 ☐ $20,000 ☐ $30,000

Critical Illness Insurance – Spouse

☐ $ 5,000 ☐ $15,000
☐ $10,000

Critical Illness Insurance – Child(ren)

☐ $10,000

9. Dependent Information for Accident and Critical Illness Plans

List all dependent information and indicate coverage for accident and/or critical illness. Attach separate sheet for additional dependents.
Marriage and/or birth certificates required for dependents enrolled in these plans.

Last Name First Name	Social Security Number	Relationship	Date of Birth	Sex	Add	Delete	**Accident**	**Critical Illness**
1.					☐	☐	☐	☐
2.					☐	☐	☐	☐
3.					☐	☐	☐	☐
4.					☐	☐	☐	☐
5.					☐	☐	☐	☐
6.					☐	☐	☐	☐

10. Spending Accounts – Health Savings Account and Flexible Spending Accounts for Health and Dependent Care

Health Savings Account – Employee Voluntary Contribution

If you enrolled in one of the County's High Deductible Health Plans, this option allows you to make voluntary pre-tax* contributions to an HSA by payroll deduction to be used for qualified medical expenses. The County will also provide funding to your HSA account if enrolled in a HDHP. **Employer contributions are included in your annual contribution.** Refer to your benefit guide for more details.
There is a monthly Wells Fargo bank service fee of $2.65.

Health Savings Account- **Wells Fargo Bank**

Maximum Annual Contribution	**–**	**Employer contribution**	**=**	**Maximum <u>voluntary</u> contribution by employee allowed per year**
EE Only $ 3,350	–	$1,250	=	**$2,100**
Family $ 6,750	–	$2,100	=	**$4,650**

Enter the amount of your voluntary semi-monthly contribution in the space below.

Semi-monthly contribution $_____ **HSA payroll deductions are <u>only</u> taken twice a month up to 24 times per year**.

***HSA contributions are not pre-tax for State.**

Flexible Spending Account- <u>Health Care</u>

This option is for voluntary pre-tax contributions to be used for Qualified Medical Expenses. There is an administrative fee deducted semi-monthly from your paycheck for the FSA plan.

If you are enrolled in an HSA, you are not eligible for this option.

Maximum Annual Contribution - $2,550

Enter the amount of your voluntary semi-monthly contribution in the space below.

Semi-monthly contribution $_____ **FSA payroll deductions are <u>only</u> taken twice a month up to 24 times per year**.

Flexible Spending Account- <u>Dependent Care</u>

This option is for voluntary pre-tax contributions to be used for eligible Dependent Care Expenses. There is an administrative fee deducted semi-monthly from your paycheck for the FSA plan.

Maximum Annual Contribution - $5,000

Enter the amount of your voluntary semi-monthly contribution in the space below.

Semi-monthly contribution $_____ **FSA payroll deductions are <u>only</u> taken twice a month up to 24 times per year**.

11. Employee Acceptance --Please read the following and acknowledge by signing below:

I hereby apply for group benefits provided under my employer's group benefit plan(s) for myself and for the eligible dependents/beneficiary's listed on this form. I understand that I have made an election for my benefits package for the Plan Year indicated on this Enrollment Form. Any choices I have made may only be altered as the result of a change in family status.

I have read and understand the provisions outlined in this form including, but not limited to the arbitration agreement and my signature below acknowledges my understanding and acceptance of these terms. All information on this form is correct and true to the best of my knowledge. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I am entitled to a copy of this signed authorization for my files.
I declare for myself and/or my dependent(s) that I am eligible to enroll in these plans and request to be covered. If the group plan requires contributions be made by me, I authorize Stanislaus County to deduct them from my pay. Should changes take place affecting these statements, I will immediately inform my employer of the change. I understand an agent cannot guarantee coverage or revise rates, benefits or plan provisions without written approval from the specific carrier. Employee personal information is protected under Federal HIPAA Law.

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 my covered eligible 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. 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.

ARBITRATION AGREEMENT (**for Anthem Blue Cross Participants**): I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision. IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES 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, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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 provided by California law, 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. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS IS WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature	Date