



# Stanislaus County Benefit Enrollment Form 2017

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 Qualifying Life Event change, you must submit this completed form and backup documentation within 60 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													
<input type="checkbox"/> New Hire		Hire Date:		<input type="checkbox"/> Change/Type		Change Date:		Dept:		Employee ID:			
Last Name:				First Name:				New Last Name: (If applicable)			MI		
Address:					City:			State:		Zip Code:			
Phone#	Home:			Work:			Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth:				
Social Security #			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married			Home Email:							
2. Medical Plan Options and Semi-Monthly Employee Pre-Tax Share of Premiums													
<b>Stanislaus County Partners in Health and Anthem Blue Cross</b>						<input type="checkbox"/> <b>Waive Medical Coverage</b> – 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 understand there are restrictions on when I would be allowed to re-enroll.  <input type="checkbox"/> I have attached a <b><u>COPY OF MY PROOF OF OTHER COVERAGE.</u></b>  <input type="checkbox"/> My spouse/parent works for the County and has covered me as a dependent.  Spouse/Parent Name: _____ Dept.: _____							
<b><u>HDHP</u></b>			<b><u>EPO</u></b>										
<input type="checkbox"/> Empl Only - \$16.04			<input type="checkbox"/> Empl Only - \$76.70										
<input type="checkbox"/> Empl + 1 - \$32.07			<input type="checkbox"/> Empl + 1 - \$153.41										
<input type="checkbox"/> Family - \$43.30			<input type="checkbox"/> Family - \$207.10										
3. Coordination of Benefits (Employee cannot have dual medical coverage if enrolling in a County High Deductible Health Plan)													
Do you currently have other medical insurance coverage?					<input type="checkbox"/> Yes <input type="checkbox"/> No		Will you be keeping your other coverage?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Name of Other Insurance Carrier/Medical Plan</b>				<b>Medical ID Number</b>				<b>Employer</b>					

#### 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
<input type="checkbox"/> Employee Only - \$3.65 <input type="checkbox"/> Employee + 1 - \$7.30 <input type="checkbox"/> Family - \$12.51 <input type="checkbox"/> Waive Dental Coverage	<input type="checkbox"/> Employee Only - \$18.29 <input type="checkbox"/> Employee + 1 - \$36.59 <input type="checkbox"/> Family - \$62.68	<input type="checkbox"/> Employee Only - \$0.86 <input type="checkbox"/> Employee + 1 - \$1.65 <input type="checkbox"/> Family - \$2.33 <input type="checkbox"/> Waive Vision Coverage

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

<b>Basic Life Employee Only – No Cost to Employee</b> <input type="checkbox"/> \$10,000 - All Full-Time Represented and Confidential Employees	<b>Basic Life and AD&amp;D Employee Only – No Cost to Employee</b> <input type="checkbox"/> \$30,000 – All Full-Time Management and Dept Head Employees <input type="checkbox"/> \$50,000 – All Full-Time Attorneys
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#### 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.

**Spouse:** (Last Name, First Name)

1.

#### 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.

**Dependent Child(ren):** (Last Name, First Name)

1.

2.

3.

4.

**This page must be completed with at least one beneficiary**

**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 benefit plans.**

Last Name, First Name	Social Security Number	Relationship	Date of Birth	Sex	Add	Delete	Medical	Dental	Vision	Basic and Supplemental Life Beneficiary's			
										Basic %	Supp %	Primary	Contingent
1.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
5.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
6.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
7.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
8.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
9.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
10.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>

**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 \$1,000 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		Spouse Rates – Issue Age		Children Rates	
Rates are per \$1,000	Semi-Monthly Rates	Rates are per \$1,000	Semi-Monthly Rates	Rates are per Benefit Level	Semi-Monthly
18-24	\$0.39	18-24	\$0.64	\$10,000	\$4.76
25-29	\$0.50	25-29	\$0.65		
30-34	\$0.60	30-34	\$0.78		
35-39	\$0.78	35-39	\$1.02		
40-44	\$1.10	40-44	\$1.47		
45-49	\$1.55	45-49	\$2.15		
50-54	\$2.07	50-54	\$3.04		
55-59	\$2.62	55-59	\$4.05		
60+ ask for rates		60+ ask for rates			

  

Critical Illness Insurance – Employee			Critical Illness Insurance – Spouse		Critical Illness Insurance – Child(ren)
<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$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			Accident	Critical Illness
						Add	Delete		
1.						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 10. Spending Accounts – Health Savings Account (HSA) and Flexible Spending Accounts (FSA) for Health and Dependent Care

**Health Savings Account – Employee Voluntary Contribution**  **Waive**

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.

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

Health Savings Account – **Optum Bank.** There is a monthly Optum Bank service fee of \$2.65 for HSA balances less than \$2,500.

**Maximum Annual Contribution – Employer Contribution = Maximum voluntary contribution by employee allowed per year**

EE Only	\$3,400	–	\$1,250	=	<b>\$2,150</b>
Family	\$6,750	–	\$2,100	=	<b>\$4,650</b>

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

**Semi-monthly contribution \$ \_\_\_\_\_ HSA payroll deductions are only taken twice a month up to 24 times per year.**

**Flexible Spending Account – Health Care**  **Enroll**  **Waive**

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 only taken twice a month up to 24 times per year.**

**Flexible Spending Account – Dependent Care**  **Enroll**  **Waive**

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 only 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/beneficiaries 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:
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