CHIEF EXECUTIVE OFFICE
Risk Management Division
Employee Benefits

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2020 Stanislaus County Benefit Enrollment Form

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 along with social security numbers are required when enrolling a new dependent in a health plan.**

1. Employee General Information

☐ New Hire	Hire Date:	☐ Change/Type:	Change Date:	Dept:	Employee ID:

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

Address:	City:	State:	Zip Code:	New Address: ☐

Home Phone:	Mobile Phone:	Work Phone:	Gender: ☐ Male ☐ Female	Date of Birth:

Social Security #:	Marital Status: ☐ Single ☐ Married	Home Email:

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

Health Partners of Northern California and UnitedHealthcare

HDHP	**EPO**
☐ Empl Only $18.50	☐ Empl Only $87.50
☐ Empl + 1 ..... $36.50	☐ Empl + 1 .....$175.50
☐ Family $49.50	☐ Family $236.50

☐ **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 understand there are restrictions on when I would be allowed to re-enroll.

☐ I have attached a **COPY OF MY PROOF OF OTHER COVERAGE**.

☐ My spouse/parent works for the County and has covered me as a dependent.

Spouse/Parent Name: Dept.:

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? ☐ 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 (Choose Only One Dental Plan)		Vision Service Plan
Core Dental Plan	**Buy-Up Dental Plan**	
☐ Employee Only.....$3.50	☐ Employee Only $15.50	☐ Employee Only $0.50
☐ Employee + 1.....$7.00	☐ Employee + 1.....$31.00	☐ Employee + 1.....$1.50
☐ Family $12.00	☐ Family.....$53.00	☐ Family.....$2.00
☐ **Waive Dental Coverage**		☐ **Waive Vision Coverage**

5. Dependent and/or Beneficiary Information for Health and Life Plans – You must list at least one beneficiary for life insurance

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 along with social security numbers are required for dependents enrolled in benefit plans.**

Last Name, First Name	Social Security Number	Relationship	Date of Birth	Gender	Add	Delete	Medical	Dental	Vision	Basic and Supplemental Life Beneficiaries*			
										*Basic%	*Supp %	*Primary	*Contingent
1.					☐	☐	☐	☐	☐			☐	☐
2.					☐	☐	☐	☐	☐			☐	☐
3.					☐	☐	☐	☐	☐			☐	☐
4.					☐	☐	☐	☐	☐			☐	☐
5.					☐	☐	☐	☐	☐			☐	☐
6.					☐	☐	☐	☐	☐			☐	☐
7.					☐	☐	☐	☐	☐			☐	☐
8.					☐	☐	☐	☐	☐			☐	☐
9.					☐	☐	☐	☐	☐			☐	☐

*All percents for Primary beneficiaries must total 100%. Contingent beneficiaries are optional and if you designate Contingent beneficiaries, they will receive benefits only if all Primary beneficiaries are deceased. All percents for Contingent beneficiaries must also total 100%.

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

Basic Life Employee Only – No Cost to Employee	Basic Life and AD&D Employee Only – No Cost to Employee
☐ $10,000 - All Full-Time Represented and Confidential Employees	☐ $30,000 – All Full-Time Management and Dept Head Employees ☐ $50,000 – All Full-Time Attorneys

Voluntary Supplemental Life and AD&D

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 and submit it directly to ReliaStar for underwriting approval.

Employee Voluntary Supplemental Life and AD&D

Guarantee Issue (GI) of $100,000 at time of hire for employee coverage; no GI at Open Enrollment.

☐ $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 Employee Supplemental Life**

☐ I selected an option **greater than the Guarantee Issue** Limit. I have completed the Evidence of Insurability form and submitted directly 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.

Spouse Voluntary Supplemental Life and AD&D – MARRIAGE CERTIFICATION IS REQUIRED

Guarantee Issue of $30,000 when spouse is first eligible; no GI at Open Enrollment. Employee must have the same or more supplemental life coverage. Employee is the beneficiary of this life insurance policy.

☐ $20,000 + AD&D..... $2.25 ☐ $30,000 + AD&D..... $3.38 ☐ **Waive Spouse Supplemental Life**

Spouse: (Last Name, First Name)	**Date of Birth:**	**Social Security Number:**

Dependent Child Voluntary Supplemental Life – DEPENDENT CERTIFICATION IS REQUIRED.

Guarantee Issue of $10,000 when child(ren) is first eligible; no GI at Open Enrollment. Employee must have the same or more supplemental life coverage. Employee is the beneficiary of this life insurance policy.

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

☐ **Waive Dependent Child Supplemental Life**

Dependent Child(ren): (Last Name, First Name)	**Date of Birth:**	**Social Security Number:**
1.		
2.		
3.		
4.		

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

You may elect coverage for your spouse up to age 70 and children up to age 26. **Certification of dependent status is required.**

☐ Employee Only... $3.77 ☐ Employee + Spouse .. $6.25 ☐ Employee + Child(ren) ... $6.85 ☐ Family ... $9.33 ☐ **Waive Accident Ins.**

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

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 at 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+ ask for rates	

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+ ask for rates	

Children Rates

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

Critical Illness Insurance – Employee

☐ $ 5,000 ☐ $10,000 ☐ $15,000
☐ $20,000 ☐ $25,000 ☐ $30,000
☐ **Waive Employee Critical Illness**

Critical Illness Insurance – Spouse

☐ $ 5,000 ☐ $10,000 ☐ $15,000
☐ **Waive Spouse Critical Illness**

Critical Illness Insurance – Child(ren)

☐ $10,000
☐ **Waive Children Critical Illness**

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.					☐	☐	☐	☐

10. Spending Accounts – Health Savings Account (HSA) and Flexible Spending Accounts (FSA) 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.

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

Health Savings Account serviced by 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 <u>Voluntary</u> Contribution by employee**	**Age 55+ Max**
Employee Only	$3,550	–	$1,250	= **$2,300**	$3,300
EE +1 or Family	$7,100	–	$2,100	= **$5,000**	$6,000

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

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

☐ **Waive voluntary HSA Contribution**

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 of $2.13 deducted semi-monthly from your paycheck for an FSA account. Your FSA accounts are serviced by P&A Group.

If you are enrolled in an HSA, you are not eligible for a Health Care FSA.

Maximum Annual Contribution - $2,750

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

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

☐ **Waive voluntary FSA Health Care Contribution**

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 of $2.13 deducted semi-monthly from your paycheck for an FSA account. Your FSA accounts are serviced by P&A Group.

Maximum Annual Contribution - $5,000

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

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

☐ **Waive voluntary FSA Dependent Care Contribution**

11. Long Term Care

At time of hire you can elect long term care coverage for you and your spouse with simplified underwriting. Simplified underwriting is a one-time opportunity that is not offered at Open Enrollment. For rates and to apply for long term care coverage, you must complete the online application by visiting https://ltcsemployer-live.azurewebsites.net/employer/stanislaus.

☐ I have completed the online application for underwriting approval. I understand I will not be charged a premium until approval from LTC Solutions is received.

☐ **Waive Long Term Care**

12. 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 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.

Signature:	Date:

For Employee Benefits Use Only:	***Initials:***		***Initials:***
ACA entered		Modify a Person data updated	
Birth event coverage begin date corrected		Dependent data updated	
HSA election		Verification documentation rcvd	
Deferred Comp form rcvd – Mgmt/Conf		Verification documentation on calendar	
Open Enrollment		Adjustments added to adjustment sheet	