CHIEF EXECUTIVE OFFICE
Human Relations Division
Employee Benefits

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2025 Stanislaus County Benefit Enrollment Form

Important Notes:

- Please complete this Benefit Enrollment Form when enrolling in benefits or making benefit changes. If completing electronically, you must download Adobe Reader (free download), sign form with Adobe signature, and return. A form with your typed signature will not be accepted.
- Each of the 14 numbered sections on this Enrollment Form must be completed or acknowledged (write "no-change" or line through the section).
- Incomplete Enrollment Forms will not be processed and will be returned.
- Check the box next to your chosen option.
- All dependent/beneficiary information including birthdate and social security number must be provided.
- Within **60 calendar days** of initial hire, open enrollment, or a Qualifying Life Event (QLE), you must submit official, certified and recorded documentation that confirms your dependent's relationship to you and/or supports the QLE.
- If documentation is not received within 60 calendar days, your dependents will be removed from coverage and any services received from benefit providers will be your sole financial responsibility.
- Refer to your Benefit eGuide for detailed information on your benefit options.
- You must use PeopleSoft self-service to update your life insurance beneficiaries.
- You must contact all voluntary benefit entities (StanCERA, Nationwide, Optum Bank) separately and directly to update beneficiary information.

1. Employee General Information					
☐ New Hire	Hire Date:	☐ QLE Type:	QLE Date:	Dept:	Employee ID:
Last Name:	First Name:	MI:	New Last Name: (If applicable)		
Home Street Address:	City:	State:	Zip Code:		
Home Phone:	Mobile Phone:	Work Phone:	Gender: ☐ Male ☐ Female	Date of Birth:	
Social Security #:	Marital Status: ☐ Single ☐ Married ☐ CA Registered Domestic Partner	Home Email:			

2. Dependent and/or Beneficiary Information – You must list at least one beneficiary for life insurance

- To enroll or change benefit elections you must provide <u>all</u> dependent information and check corresponding boxes.
- You must provide at least one beneficiary for your life insurance plan(s).
- For life insurance beneficiaries, indicate % of benefit and whether your beneficiary is "Primary" or "Contingent" using whole numbers.
- Both Primary and Contingent % must be stated in whole numbers and must equal 100%.
  EXAMPLE: Acceptable: 33%, 33% and 34%. Not Acceptable: 33.3%, 33.3% and 33.3%.
- Contingent beneficiaries are optional and will receive benefits only if all Primary beneficiaries are deceased.
- 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	Medical	Dental	Vision	Accident Insurance	Critical Illness	Spousal Life	Dependent Life	Basic and Supplemental Life Beneficiaries*			
												Basic Life	Supplemental	Primary %	Contingent %
1.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 1 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			
2.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 2 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			
3.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 3 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			
4.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 4 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			
5.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 5 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			
6.					☐	☐	☐	☐	☐	☐	☐	☐	☐		
Remove Dependent listed in row 6 from the checked benefits.					☐	☐	☐	☐	☐	☐	☐	Employee Must Change Via PeopleSoft			

3. Choose a Medical Plan Option or Waive Medical Coverage (Employee Pre-Tax share of premiums are taken semi-monthly)

- Medical Provider Networks are assigned and determined by your Home/Residential address.
- Employees may not have dual medical coverage if enrolled in the Stanislaus County High Deductible Health Plan (HDHP).

1. Do you currently have other medical coverage? ☐ Yes – Answer Question 2 ☐ No – You may choose either HDHP or EPO
2. Will you be keeping the other medical coverage? ☐ Yes – You may only enroll in the EPO ☐ No – You may choose either HDHP or EPO

High Deductible Health Plan (HDHP)……	☐ Employee Only.....$22.50	☐ Employee + 1..... $45.00	☐ Family $60.50
Exclusive Provider Organization (EPO)……..	☐ Employee Only..... $107.50	☐ Employee + 1.....$215.50	☐ Family $291.00

3a. I choose to Waive medical coverage ☐

- I understand that I am freely waiving the right to participate in medical coverage benefits. *Initials* ☐
- I understand the County provides a waive credit in the manner approved by the Board of Supervisors for employees in my classification. *Initials* ☐
- I understand that there are restrictions governing the qualifying conditions upon which I will be allowed to reenroll in a medical plan. *Initials* ☐
- I have attached a copy of my proof of other coverage or provide the information below. *Initials* ☐

3b. Name of Other Insurance Carrier/Medical Plan	Medical ID Number	Employer Providing the Plan

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

Spouse/Parent Name: **Dept.**:

4. Dental Plan Options – Choose only one option (Employee Pre-Tax share of premiums are taken semi-monthly)

Delta Dental Core Plan……	☐ Employee Only $2.75	☐ Employee + 1 ..... $6.00	☐ Family $10.50
Delta Dental Buy-Up Plan*……..	☐ Employee Only $12.25	☐ Employee + 1 .....$25.00	☐ Family $43.00

**You must remain enrolled for 3 years*

☐ **Waive Dental Coverage**

5. Vision Plan Options – Choose only one option (Employee Pre-Tax share of premiums are taken semi-monthly)

Vision Service Plan (VSP)……	☐ Employee Only..... $0.70	☐ Employee + 1..... $1.58	☐ Family $2.10

☐ **Waive Vision Coverage**

6. Accident Insurance – Choose only one option (Employee After-Tax premiums are taken semi-monthly)

You may elect coverage for your spouse up to age 70 and children up to age 26.

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

☐ **Waive Accident Coverage**

7. Basic Life or Basic Life AD&D Insurance (Provided to employees at no cost as listed below)

☐ All Full-Time **Represented** and **Confidential** Employees: $10,000 Basic Life Employee Only
☐ All Full-Time **Management** and **Department Head** Employees: $30,000 Basic Life and AD&D Employee Only
☐ All Full-Time **Attorneys:** $50,000 Basic Life and AD&D Employee Only

8. Voluntary Supplemental Life and AD&D (Employee After-Tax premiums are taken semi-monthly)

- Only at your time of hire may you elect voluntary Supplemental Life and AD&D coverage up to the Guarantee Issue (GI) Limit of $100,000 without an Evidence of Insurability (EOI) form approved by ReliaStar. Please note there is no GI at Open Enrollment.
- If you elect any amount of coverage after your initial hire, you are required to complete an EOI form and submit it directly to ReliaStar for underwriting approval.

☐ $20,000 + AD&D..... $2.10 ☐ $30,000 + AD&D .... $3.15 ☐ $50,000 + AD&D..... $5.25 ☐ $100,000 + AD&D $10.50
☐ $150,000 + AD&D..... $15.75 ☐ $200,000 + AD&D….$21.00 ☐ $250,000 + AD&D.... $26.25 ☐ $300,000 + AD&D $31.50

☐ **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.

9. Dependent Child Voluntary Supplemental Life (Employee After-Tax premiums are taken semi-monthly)

- Dependent certification is required.
- Employee must have equal or more coverage in the Voluntary Supplemental Life and AD&D insurance plan.
- Guarantee Issue of $10,000.
- Employee is the sole beneficiary of this life insurance policy.

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

☐ **Waive Dependent Child Supplemental Life**

10. Spouse Voluntary Supplemental Life and AD&D (Employee After-Tax Premiums are taken semi-monthly)

- Marriage certification is required.
- Employee must have the same or more coverage in the Voluntary Supplemental Life and AD&D insurance plan.
- Guarantee Issue of $30,000 when spouse is first eligible. There is no GI at Open Enrollment.
- Employee is the sole beneficiary of this life insurance policy.

☐ $20,000 + AD&D..... $2.10 ☐ $30,000 + AD&D.....$3.15

☐ **Waive Spouse Supplemental Life**

11. Critical Illness Insurance (Employee After-Tax premiums are taken semi-monthly)

- Marriage/Dependent certification required.
- Employee must have the same or more Critical Illness Insurance coverage as spouse or child selection.
- The semi-monthly rates for Critical Illness Insurance below are **per $1,000 based on age at enrollment.**

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	

Critical Illness Insurance – Employee

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

☐ **Waive Employee Critical Illness**

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	

Critical Illness Insurance – Spouse

☐ $ 5,000 ☐ $10,000 ☐ $15,000

☐ **Waive Spouse Critical Illness**

Children Rates

$10,000	$4.76

Semi-monthly premium covers all children enrolled.

Critical Illness Insurance – Child(ren)

☐ $10,000

☐ **Waive Children Critical Illness**

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

12a. FSA Health Care – HDHP plan participants with HSA are not eligible (Employee Pre-Tax deductions are taken semi-monthly)

- Health Care Flexible Spending Accounts are voluntary pre-tax contributions to be used for Qualified Medical Expenses.
- You will be charged an administrative fee of $2.13 deducted semi-monthly from your paycheck for an FSA account.
- 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 - $3,300

FSA payroll deductions are only taken twice a month, up to 24 times per year.

☐ **Enroll: Annual* Contribution** $ _____ * Contribution will be divided by remaining paychecks in current calendar year

☐ **Waive voluntary FSA Health Care Contribution**

12b. FSA Dependent Care – All full-time employees are eligible (Employee Pre-Tax deductions are taken semi-monthly)

- Dependent Care Flexible Spending Accounts are 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.
- FSA accounts are serviced by P&A Group.
- Maximum Annual Contribution - $5,000

FSA payroll deductions are only taken twice a month, up to 24 times per year.

☐ **Enroll: Annual* Contribution $** _____ *Contribution will be divided by remaining paychecks in current calendar year

☐ **Waive voluntary FSA Dependent Care Contribution**

12c. HSA – Only HDHP plan participants are eligible (Employee Pre-Tax* deductions are taken semi-monthly)

Employee Voluntary HSA Contributions

- If you enrolled in the County's High Deductible Health Plan (HDHP), this option allows you to make voluntary pre-tax* contributions to your HSA.
- Contributions are pre-tax* contributions to be used for Qualified Medical Expenses.
- Voluntary contributions are in addition to the County's Employer contributions made into your HSA account.
- **Employer contributions are included in your maximum annual contribution.**
- Health Savings Accounts are serviced by Optum Bank. There is a monthly Optum Bank service fee of $2.65 for HSA balances less than $2,500.

HSA contributions are not pre-tax for State.

Employee Only	$4,300 IRS Maximum Annual Contribution Allowed	–	$1,350 Annual County Contribution	=	**$2,950** Maximum Annual Voluntary Employee Contribution Allowed	**or**	$3,950 (Age 55+) Maximum Annual Voluntary Employee Contribution Allowed if Age 55+
Employee +1 or Family	$8,550 IRS Maximum Annual Contribution Allowed	–	$2,600 Annual County Contribution	=	**$5,950** Maximum Annual Voluntary Employee Contribution Allowed	**or**	$6,950 (Age 55+) Maximum Annual Voluntary Employee Contribution Allowed if Age 55+

HSA payroll deductions are only taken twice a month, up to 24 times per year.

☐ **Enroll: Annual* Contribution** $ _____ *Contribution will be divided by remaining paychecks in current calendar year

☐ **Waive voluntary HSA Contribution**

13. Long Term Care

- Long Term Care enrollment is not currently available.
- Information will be posted on the Benefits website when enrollment becomes available.

14. 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 Qualifying Life Event (QLE) or during an annual Open Enrollment period.

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. 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. I understand that employee personal information is protected under Federal HIPAA Law.

I understand that if the group plan requires that contributions be made by me, I authorize Stanislaus County to deduct them from my pay. I further understand that the County will continue to establish medical insurance premium rates each year based on actuarial and underwriting recommendations and the County reserves the right to adjust medical insurance premium rates based on these recommendations. I understand I am responsible for paying any increase in monthly premium rates made due to these recommendations.

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 acknowledging notification of my continuation rights under COBRA.

Signature:	Date:

For Office Use Only:	***Initials:***	***Date:***
ACA Entered		
Birth event coverage begin date corrected		
HSA Election if no ER contribution		