San Joaquin County Health Benefits Enrollment Form 2019 – 2020
Sheriff's Unit K Only

Reason for Enrollment Form: ☐ Open Enrollment ☐ New Hire ☐ Qualifying Life Event: _____ (Describe)

For HR staff use only
Effective Date:_____

For any questions or to submit this form, contact Human Resources Employee Benefits Office at (209) 468-9987
Email: employeebenefits@sjgov.org. Fax: (209) 468-9734. Mailing address: 44 North San Joaquin Street Suite 330, Stockton, CA 95202

Employee Personal Information			
First Name, Middle Initial, Last Name:		Employee ID#:	
Street Address:	City:	State:	Zip Code:
Date of Birth:	Social Security Number:		
Best Contact Phone Number: ☐Mobile ☐Home			☐Male ☐Female
Email Address:			

Medical Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Medical Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐Select Exclusive Plan	☐Employee Only	Select Exclusive	$0.00	$231.84	$324.58
☐Select Plan	☐Employee + One	Select Plan	$0.00	$231.84	$324.58
☐Premier Plan	☐Employee + Family	Premier Plan	$48.67	$329.17	$460.83
☐Kaiser Permanente HMO		Kaiser HMO Plan	$0.00	$134.95	$190.95
☐Opt-Out of Medical					

Employee's Primary Care Physician (PCP) name for Select Exclusive, Select, or Premier (required):
(Dependent PCP's will be listed on back)

Dental Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Dental Plan Options	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐Delta Dental	☐Employee Only	Delta Dental	$0.00	$19.39	$46.39
☐United Healthcare (UHC) Dental	☐Employee + One	UHC Dental	$0.00	$9.64	$18.15
☐Opt-Out of Dental	☐Employee + Family				

Your dental office for UHC Dental (required):

Vision Plan Option

Vision Plan	**Coverage Level**	**Bi-Weekly Rates**	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
☐Vision Service Plan (VSP)	☐Employee Only	VSP	$0.00	$2.63	$6.79
☐Opt-Out of Vision	☐Employee + One				
	☐Employee + Family				

Section 125 – Flexible Spending Accounts

Enter the annual election for the plans you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the fiscal year you are electing coverage for. (The months with 3 paychecks, only 2 paychecks have deductions).

Plan Options

Medical Spending Account
(Elect up to $2,700 for 2019 – 2020 annually) $_____ annually

Dependent Day Care Account
(Elect up to $5,000 for 2019 – 2020 annually) $_____ annually

☐ I acknowledge that I have received a copy of the **Rules of Participation** and understand and agree to the terms and conditions of participation in the Flexible Spending Account(s), including those of the Flexible Spending Account Card.

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Eligible Dependent Coverage							
Check the box for the health services you wish to enroll your eligible dependents. You, as the employee, must be enrolled in the plan if you want your dependent(s) enrolled. If your dependents are enrolled, the plan selection(s) must be the same as the employee. **Required Documentation:** Social Security Number for all, Marriage Certificate (spouse), Birth Certificate (child), Certificate of Partnership (registered domestic partner), court paperwork (adopted child/legal guardianship)							
Dependent(s) Name (spouse and/or children)	**Relation-ship**	**Date of Birth**	**Social Security Number (required)**	**Medical**	**Dental**	**Vision**	**Primary Care Physician (PCP)**

Other Medical Coverage:
Is your spouse or any of your eligible dependents covered by another group medical plan, including San Joaquin County coverage, MediCal, or Medicare?
☐Yes. Name and Address of Other Medical Coverage_____
☐No. I certify that my spouse and/or dependents are not covered by any other medical coverage.

Kaiser Foundation Health Plan Arbitration Agreement
Please read and sign if you are electing the Kaiser plan (required).

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not be lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full Arbitration provision is contained in the Evidence of Coverage.

Employee Signature **Date**

Qualifying Life Events
If you obtain a new dependent (through marriage, birth, adoption, registered domestic partnership, legal guardianship) or if you or your dependents lose medical, dental, and/or vision coverage, you must request enrollment in the County's plans within 60 days of the date of the event. If you do not request enrollment within 60 days, you or your dependent must wait until the next County Open Enrollment period before you can enroll and/or make changes. It is also the employee's responsibility to delete a spouse or dependent from coverage within 60 days of an event that makes the dependent ineligible for benefits (such as divorce or over-age child).

By signing below, I acknowledge that deductions are taken out of my pay check on a pre-tax basis. I must provide all dependent verification documentation within 60 days from my date of hire or qualifying life event. Rates are negotiated through my bargaining unit and approved by the Board of Supervisors. All dependents enrolled must be eligible. I understand that falsification of information by me will allow my employer to recover payments made, cancel my coverage, refuse payment of claims, and may include discipline.

Signature:_____ **Date**_____