

**San Joaquin County Domestic Partner Health Benefits Enrollment Form 2024 – 2025
Cafeteria Employees**



Reason for Enrollment Form: Open Enrollment New Hire Qualifying Life Event: _____ For HR staff use only
(Describe) 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

Please complete this form and attach to your primary open enrollment form. Your plan options are the same as you have selected for yourself. The rates listed below are in addition to the rates for your primary plan.

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:	<input type="checkbox"/> Mobile	<input type="checkbox"/> Home	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address:			

Coverage Level Description

- 5:** Employee has **Employee-Only** coverage and has added a **domestic partner adult**
- 6:** Employee has **Employee Plus One Dependent** coverage on their regular plan and has added a **domestic partner adult** and **may have added domestic partner child(ren)**
- 7:** Employee has **Employee-Only** coverage and has added a **domestic partner adult and domestic partner child(ren)**
- 8:** Employee has **Employee Plus Two or More Dependents** coverage and has added a **domestic partner adult and may have added domestic partner child(ren)**

Medical Plan Options						
You are currently enrolled in...						
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	5***	6***	7***	8***
<input type="checkbox"/> Select Exclusive Plan	<input type="checkbox"/> 5	Select Exclusive	\$777.42	\$621.93	\$1,399.35	\$0.00
<input type="checkbox"/> Select Plan	<input type="checkbox"/> 6	Select Plan	\$777.42	\$621.93	\$1,399.35	\$0.00
<input type="checkbox"/> Premier Plan	<input type="checkbox"/> 7	Premier Plan	\$842.69	\$674.14	\$1,516.83	\$0.00
<input type="checkbox"/> Sutter Health Plus HMO	<input type="checkbox"/> 8	Sutter Health Plus	\$429.73	\$356.66	\$786.39	\$0.00
<input type="checkbox"/> Kaiser Permanente HMO		Kaiser HMO Plan	\$443.08	\$367.76	\$810.84	\$0.00
<input type="checkbox"/> Sutter Health Plus – High Deductible Health Plan (HDHP)		Sutter Health Plus HDHP	\$323.07	\$268.14	\$591.21	\$0.00
<input type="checkbox"/> Kaiser Permanente – High Deductible Health Plan (HDHP)		Kaiser HDHP	\$339.19	\$281.52	\$620.71	\$0.00
<input type="checkbox"/> Opt-Out of Medical						

-Employee's Primary Care Physician (PCP) code for Sutter Health Plus (required):
(Dependent PCP codes need to be listed on back)
-Go to www.sutterhealthplus.org/provider-search to find a PCP or one will be auto-assigned to you)

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Dental Plan Options						
You are currently enrolled in...						
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	5***	6***	7***	8***
<input type="checkbox"/> Delta Dental (Standard)	<input type="checkbox"/> 5	Delta Dental (Standard)	\$13.76	\$19.17	\$32.93	\$0.00
<input type="checkbox"/> Delta Dental (Core)	<input type="checkbox"/> 6					
<input type="checkbox"/> Delta Dental (Buy Up)	<input type="checkbox"/> 7	Delta Dental (Core)	\$13.36	\$18.59	\$31.95	\$0.00
<input type="checkbox"/> United Healthcare (UHC) Dental	<input type="checkbox"/> 8					
<input type="checkbox"/> Opt-Out of Dental		Delta Dental (Buy Up)	\$14.51	\$20.19	\$34.70	\$0.00
		UHC Dental	\$11.55	\$10.21	\$21.76	\$0.00

Your dental office for UHC Dental (required): _____

Vision Plan Option						
You are currently enrolled in...						
Vision Plan	Coverage Level***	Bi-Weekly Rates	5***	6***	7***	8***
<input type="checkbox"/> VSP (Standard)	<input type="checkbox"/> 5	VSP (Standard)	\$2.36	\$3.71	\$6.07	\$0.00
<input type="checkbox"/> VSP (Buy Up)	<input type="checkbox"/> 6					
<input type="checkbox"/> Opt-Out of Vision	<input type="checkbox"/> 7	VSP (Buy Up)	\$4.16	\$6.57	\$10.73	\$0.00
	<input type="checkbox"/> 8					

Current Domestic Partner 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)

<p>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?</p> <p><input type="checkbox"/> Yes. Name and Address of Other Medical Coverage _____</p> <p><input type="checkbox"/> No. I certify that my spouse and/or dependents are not covered by any other medical coverage.</p>

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** _____