San Joaquin County Domestic Partner Health Benefits Enrollment Form 2025 – 2026
Cafeteria Employees

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

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:	☐Mobile ☐Home		☐Male ☐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*** **
☐Select Exclusive Plan ☐Select Plan ☐Premier Plan ☐Sutter Health Plus HMO ☐Kaiser Permanente HMO ☐Sutter Health Plus – High Deductible Health Plan (HDHP) ☐Kaiser Permanente – High Deductible Health Plan (HDHP) ☐Opt-Out of Medical	☐5 ☐6 ☐7 ☐8	Select Exclusive	$823.28	$658.63	$1,481.91	$0.00
		Select Plan	$823.28	$658.63	$1,481.91	$0.00
		Premier Plan	$892.41	$713.91	$1,606.32	$0.00
		Sutter Health Plus	$462.90	$384.18	$847.08	$0.00
		Kaiser HMO Plan	$459.01	$380.97	$839.98	$0.00
		Sutter Health Plus HDHP	$350.93	$285.78	$636.71	$0.00
		Kaiser HDHP	$351.26	$291.53	$642.79	$0.00

-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/find-provider 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*** **
☐Delta Dental (Standard) ☐Delta Dental (Core) ☐Delta Dental (Buy Up) ☐United Healthcare (UHC) Dental ☐Opt-Out of Dental	☐5 ☐6 ☐7 ☐8	Delta Dental (Standard)	$16.26	$22.64	$38.90	$0.00
		Delta Dental (Core)	$15.78	$21.95	$37.73	$0.00
		Delta Dental (Buy Up)	$17.14	$23.85	$40.99	$0.00
		UHC Dental	$12.43	$10.97	$23.40	$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*** **
☐VSP (Standard) ☐VSP (Buy Up) ☐Opt-Out of Vision	☐5 ☐6 ☐7 ☐8	VSP (Standard)	$2.35	$3.70	$6.05	$0.00
		VSP (Buy Up)	$4.15	$6.56	$10.71	$0.00

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)**

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.

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**_____