

San Joaquin County Health Benefits Enrollment Form 2021 – 2022

Employees in Unit K (Sheriff Deputies)



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

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:			

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
<input type="checkbox"/> Select Exclusive Plan <input type="checkbox"/> Select Plan <input type="checkbox"/> Premier Plan <input type="checkbox"/> Sutter Health Plus HMO <input type="checkbox"/> Kaiser Permanente HMO <input type="checkbox"/> Opt-Out of Medical	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family	Select Exclusive	\$132.94	\$265.87	\$372.22
		Select Plan	\$132.94	\$265.87	\$372.22
		Premier Plan	\$188.75	\$377.49	\$528.47
		Sutter Health Plus	\$75.40	\$150.81	\$213.42
		Kaiser HMO Plan	\$76.10	\$152.19	\$215.35
		-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)			

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
<input type="checkbox"/> Delta Dental (Standard) <input type="checkbox"/> Delta Dental (Core) <input type="checkbox"/> Delta Dental (Buy Up) <input type="checkbox"/> United Healthcare (UHC) Dental <input type="checkbox"/> Opt-Out of Dental	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family	Delta Dental (Standard)	\$0.00	\$18.42	\$44.07
		Delta Dental (Core)	\$0.00	\$17.88	\$42.76
		Delta Dental (Buy Up)	\$1.04	\$20.45	\$47.48
		UHC Dental	\$0.00	\$9.52	\$17.92
		Your dental office for UHC Dental (required):			

Vision Plan Option					
Vision Plan	Coverage Level	Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
<input type="checkbox"/> VSP (Standard) <input type="checkbox"/> VSP (Buy Up) <input type="checkbox"/> Opt-Out of Vision	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One <input type="checkbox"/> Employee + Family	VSP (Standard)	\$0.00	\$2.61	\$6.72
		VSP (Buy Up)	\$2.01	\$6.61	\$13.90

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Section 125 – Flexible Spending Accounts

If you have elected to enroll in either of the High Deductible Health Plan options, you are ineligible to enroll in the Medical Flexible Spending Account. You may elect the Health Savings Account in lieu of the Medical Flexible Spending Account listed above.

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.) ***New Hires can enroll, but on a prorated amount.**

Plan Options

Medical Spending Account

(Elect up to \$2,750* for 2021 – 2022 annually) \$_____ annually

Dependent Day Care Account

(Elect up to \$5,000 for 2021 – 2022 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.

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.

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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

Sutter Health Plus Plan Arbitration Agreement

Please read and sign if you are electing the Sutter Health Plus plan (required).

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plus (SHP) handles/resolves member disputes through grievance, appeal and independent medical review processes. In the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes. As a condition of your membership in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

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 _____