

# San Joaquin County Health Benefits Enrollment Form 2021 – 2022

Employees in Unit: X (Non-CRNAs)



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](mailto: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<br><input type="checkbox"/> Select Plan<br><input type="checkbox"/> Premier Plan<br><input type="checkbox"/> Kaiser Permanente HMO<br><input type="checkbox"/> Opt-Out of Medical | <input type="checkbox"/> Employee Only     | Select Exclusive | \$132.94      | \$265.87                 | \$372.22          |
|                                                                                                                                                                                                                                  | <input type="checkbox"/> Employee + One    | Select Plan      | \$132.94      | \$265.87                 | \$372.22          |
|                                                                                                                                                                                                                                  | <input type="checkbox"/> Employee + Family | Premier Plan     | \$188.75      | \$377.49                 | \$528.47          |
|                                                                                                                                                                                                                                  |                                            | Kaiser HMO Plan  | \$76.10       | \$152.19                 | \$215.35          |

| 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<br><input type="checkbox"/> United Healthcare (UHC) Dental<br><input type="checkbox"/> Opt-Out of Dental | <input type="checkbox"/> Employee Only  | Delta Dental    | \$0.00        | \$18.42                  | \$44.07           |
|                                                                                                                                                | <input type="checkbox"/> Employee + One | 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"/> Vision Service Plan (VSP)<br><input type="checkbox"/> Opt-Out of Vision | <input type="checkbox"/> Employee Only  | VSP             | \$0.00        | \$2.61                   | \$6.72            |
|                                                                                                  | <input type="checkbox"/> Employee + One |                 |               |                          |                   |
| <input type="checkbox"/> 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). <b>*New Hires can enroll, but on a prorated amount</b> |                   |
| Plan Options                                                                                                                                                                                                                                                                                                                                                                |                   |
| Medical Spending Account<br>(Elect up to \$2,750* for 2021 – 2022 annually)                                                                                                                                                                                                                                                                                                 | \$ _____ annually |
| Dependent Day Care Account<br>(Elect up to \$5,000 for 2021 – 2022 annually)                                                                                                                                                                                                                                                                                                | \$ _____ annually |
| <input type="checkbox"/> I acknowledge that I have received a copy of the <b>Rules of Participation</b> 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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Employees in Unit: X (Non-CRNAs)



## 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 as well. 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)<br>Name (spouse<br>and/or children) | Relation-<br>ship | Date of Birth | Social Security<br>Number (required) | Medical | Dental | Vision | Primary Care<br>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: \_\_\_\_\_