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: ____________ (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	$132.94	$265.87	$372.22
☐Select Plan	☐Employee + One	Select Plan	$132.94	$265.87	$372.22
☐Premier Plan	☐Employee + Family	Premier Plan	$188.75	$377.49	$528.47
☐Kaiser Permanente HMO		Kaiser HMO Plan	$76.10	$152.19	$215.35
☐Opt-Out of Medical					

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	$18.42	$44.07
☐United Healthcare (UHC) Dental	☐Employee + One	UHC Dental	$0.00	$9.52	$17.92
☐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	$2.61	$6.72
☐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). ***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.

San Joaquin County Health Benefits Enrollment Form 2021 – 2022

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) 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:** _____________________________________

GROUP TERM LIFE INSURANCE
BI-WEEKLY RATES FOR ADDITIONAL INSURANCE

The County provides Group Term Life Insurance for all employees who are eligible for County benefits. Eligible employees may purchase additional insurance in $25,000 increments from the County's current insurance carrier, ReliaStar. Payroll deductions for additional life insurance are deducted bi-weekly.

All members may purchase up to $200,000.

COVERAGE	BI-WEEK RATE
$25,000	$3.20
$50,000	$6.39
$75,000	$9.59
$100,000	$12.78
$125,000 *	$15.98
$150,000 *	$19.17
$175,000 *	$22.37
$200,000 *	$25.56

Evidence of Insurability Required for Amounts over $100,000 and any amount after 31 days from date of hire.

Peace of mind
when it's needed the most

Funeral Planning Services

Available to employees who are covered for group life insurance through their employer. Funeral planning and concierge services are provided by Everest Funeral Package, LLC.

Everest is pleased to provide a value-added service that empowers individuals who are dealing with funeral related issues.

While you can't predict life's outcome,
you can prepare for it.

Who is Everest?

Everest, the first nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues and then put those wishes into action.

You're never locked into a decision because Everest's funeral advisory services can be used at any funeral home across North America.

Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor does Everest receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment, allowing you and your family to make well-informed and confident decisions during a stressful time.

Everest offers both pre-planning and at-need services at or near the time of need. Everest's online planning tools help you prepare for the future. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home. Everest Advisors are available by phone 24/7 and can determine eligibility for the expedited life insurance claim process.

EVEREST
FUNERAL CONCIERGE

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

VOYA FINANCIAL

Everest's services include

Who is eligible?

Everest can be used to plan a funeral for an employee; a spouse or domestic partner; or an employee's dependents up to age 26.*

Pre-planning Services

24/7 advisor assistance

- To discuss funeral planning issues

PriceFinder℠ research reports

- The only nationwide database of funeral home prices
- Detailed, local funeral home price comparisons

Online planning tools

Include

- Personal profile
- "10 key decisions" planner
- "My Wishes" planning guide
- Reference guide

Information stored and maintained in a secure data warehouse

At-need Services

At-need family support

- Family assistance and plan implementation
- Communicate the personal funeral plan to the funeral home, removing the family from a sales-focused environment
- Provide 24-hour assistance throughout the funeral process
- Expedited life insurance claim process. Eligible beneficiaries may have access to a portion of the life insurance funds in as little as two business days following receipt of the claim form.**

Negotiation assistance

- Gather pricing information and present it to the family in an easy-to-read format
- Negotiate funeral service pricing with local funeral homes
- Help the family compare prices of caskets and other products

* Spouse or domestic partner coverage varies depending on the terms of your employer's group life insurance policy.

**Availability may vary by state.

Getting started

Group name: CSAC-EIA
Group number: 316407

Create an online profile and use Everest's planning tools visit **everestfuneral.com/voya**

- Enter your email address and your employer's name
- Create a password and complete your online profile
- Access "Planning Tools"

If you do not have access to a computer, Everest advisors are available 24/7 by calling **1-800-913-8318**.

EVEREST FUNERAL CONCIERGE

Contact your employer for more information.

Funeral Planning and Concierge Services are provided byEverest Funeral Package, LLC, Houston, TX.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies
Products and services may not be available in all states.

204332-02012019

VOYA FINANCIAL

County of San Joaquin Enrollment/Participation Agreement

Return this form to the Auditor-Controller's Payroll,
44 N. San Joaquin Street, Ste 550, Stockton CA 95202

Fax Number: 209-468-0408

Section A - Plan and Participant Information

Account No **62116-1-1**	Social Security Number	Employer **County of San Joaquin 457b**	Employee ID:
Participant Name (Last, First, M.I.)		Daytime Phone Number	
Mailing Address	City	State	Zip Code
E-mail	Gender: ☐ Male ☐ Female / Marital Status: ☐ Single ☐ Married	Hire Date	Date of Birth

Section B - Contributions

Elective Deferral Per Pay Period *($10.00 Minimum)*

1. ☐ **BEFORE TAX:** I elect to contribute $ ________ or ________ % of my compensation each payroll period on a before-tax basis.
2. ☐ **AFTER TAX:** I elect to contribute $ ________ or ________ % of my compensation each payroll period on an after-tax basis.
3. ☐ I do not elect to contribute a portion of my salary at this time.

Section C - Investment Elections

Future contributions will be invested in an age-based target investment option. You may select an investment option from the investments made available to your plan. To make any investment elections or changes please visit **www.retiresmart.com or call 1-800-743-5274**.

The employee acknowledges that he or she has had an opportunity to review the important plan disclosures included in the plan welcome/enrollment package previously delivered to the employee, and that important plan disclosure information can also be obtained by contacting MassMutual at 1-800-743-5274 or linking to Account Access from www.retiresmart.com.

Section D - Beneficiary Designation

I designate the following beneficiary(ies) in accordance with the 457(b) Deferred Compensation Plan

Primary Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			PRIMARY TOTAL:	100%

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100 %.)

Contingent Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			CONTINGENT TOTAL:	100%

NOTE: If you are married and designate your spouse for less than 100% of your death benefit, you must complete a full Beneficiary Designation/Spousal Consent form. You can obtain this via your payroll department.

NOTE: MassMutual will not display Contingent Beneficiary information on our participant website at www.retiresmart.com. An electronic copy of this form is kept on record.

Section E - Employee Agreement and Signature

If elected above, I authorize that any Before-Tax or After-Tax Contributions indicated above be made by reducing the Employee's net pay. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 457(b) contributions to ensure the Plan satisfies the requirements of Section 457(b). The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

Participant Signature ______________________ Date ______________

Section F - Important Information

BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:		Examples of Designations:
One Beneficiary		Jane Doe, wife, 100%
Two or more Primary Beneficiaries, equally among the survivors		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, with their share to their children		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries	either or	Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% equally among the survivors per stirpes
Participant’s Estate		Participant’s Estate
Trustee		Jane Doe, trustee under trust agreement* dated...

* Date of the execution of the trust agreement or a copy of the trust agreement must be provided.

A Health Net Company℠

Andre Hamil
We help our MHN members get the support they need.

Your Employee Assistance Program

How can we help?

Life can be complicated. With MHN, getting help is easy.

Your EAP is here to help with life's many challenges. MHN provides the following services, paid for by your employer.

Problem-solving support

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

When you call, you can make an appointment that works for you:

- **Face-to-face sessions** – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video consultations** – Easily accessed support provided by a network provider or MHN consultant.

Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life![1] Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need caring for children or elders in your life. Then we'll give you names and numbers of providers in your area with confirmed openings.
- **Financial services** – Talk to an advisor over the phone about:

  - Budgeting
  - Credit and financial questions (investment advice, loans and bill payments not included)
  - Retirement planning
- **Legal services** – Talk to a lawyer over the phone or face to face about:
  - Civil, consumer and criminal law
  - Personal and family law, including adoption, divorce and custody issues

(continued)

[1]Please contact us for details, including limitations and exclusions.

- Financial or tax matters. (Business matters are excluded. Also excluded are any disputes or actions between members and their employer, business partners, MHN, Health Net, or their affiliates.)
  - Real estate
  - Estate planning

- **Identity theft recovery services** – Speak with a certified consumer credit counselor who can learn more about your situation and help you create a plan. If there is a potential of ID theft, we'll connect you to an identity recovery specialist.
- **Daily living services** – Need help with errands? Planning an event or a vacation? We'll track down businesses and consultants for you. (MHN does not cover the cost nor guarantee delivery of vendors' services.)

Our member website can help with:

- Childcare and eldercare directories.
- Tips, tools and calculators to help you with finances, legal issues and retirement planning.

Health and wellness resources

Take charge of your well-being! MHN can help. Just register on our member website to:

- Assess your health and get tips for living better.
- Track progress toward your wellness goals.
- Take advantage of interactive e-learning programs.
- Find articles and videos about health topics.

Call your EAP number to learn more about our wellness coaching services – personalized support to help you set and reach your wellness goals.

This is just a summary. For details about services and eligibility, please contact MHN or your employer, or check your plan documents (such as an *Evidence of Coverage* booklet or *Summary Plan Description*).

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

Need help?

Call toll-free, 24 hours a day, seven days a week: 1-800-242-6220
TTY users call 711.
Or visit us at: members.mhn.com
and register with the company code: sanjoaquin

You are entitled to up to 5 face-to-face sessions or telephonic or web-video consultations for problem-solving support per incident, per plan period.
Separate limits apply for work-life consultations.

We speak your language!

When you call MHN, free interpretation services are available in over 170 languages. We also contract with a vendor who can physically attend appointments with you, at no cost, if you need help communicating with doctors or other providers.

¡Hablamos su mismo idioma!

Cuando llame a MHN, podrá usar nuestros servicios de interpretación gratuitos en más de 170 idiomas. Además, contamos con proveedores contratados que pueden asistir en persona a las citas con usted, sin cargo alguno, en caso de que necesite ayuda para comunicarse con los médicos u otros proveedores.

我們說您的語言!
您致電 MHN 時，我們可提供 170 多種語言的免費傳譯服務。我們還聘用了翻譯人員，如果您需要翻譯人員幫助您與醫生或其他醫療服務提供者進行交流，該翻譯人員可以與您一道參加約診，該服務爲免費提供。

Security when you travel

Voya Travel Assistance

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependents will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Available services

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: Pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Pre-trip information

These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency personal services

In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/ translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

If you need emergency or pre-trip services...

...use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program.

You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described.

Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year for: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Group name: CSAC-EIA / Group number: 316407
In the US, toll-free: 800.859.2821
Worldwide, collect: 202.296.8355
Email: ops@europassistance-usa.com
Online portal:
https://eservices.europassistance-usa.com/sites/Voya
Group ID: N1VOY
Activation code: 140623

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

Emergency transportation services*

Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance- designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf. Additional transportation services include:

- Visit of family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

* The services listed above are subject to a maximum total payment of $150,000.

Medical assistance services include:

- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant)

How it works

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services. It is recommended that you keep a copy of this summary with your travel documents. Use the wallet card to have convenient access to the numbers that you need.

Exclusions and limitations

A. Voya Travel Assistance shall not provide services enumerated above if the service is sought as a result of your or your dependent's:

Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power;

- Travel against the advice of a physician;
- Travel for the purpose of obtaining medical treatment;
- Travel in any country in which the U.S. State Department issued travel restrictions;
- Commission of or attempt to commit an unlawful act;
- Being under the influence of drugs or intoxicants unless prescribed by a physician;
- Pregnancy and childbirth (except for complications of pregnancy);
- Mental or emotional disorders, unless hospitalized;
- Participation as a professional in athletics;
- Services provided for which no charge is normally made;
- Travel within 100 miles of your permanent residence, unless in a foreign country.

B. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, Voya Travel Assistance may not be able to respond in the usual manner. It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. Voya Travel Assistance also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit Voya Travel Assistance to fully provide services.

C. If you request a transport related to a condition that has not been deemed medically necessary by a physician designated by Voya Travel Assistance in consultation with a local attending physician or to any condition excluded hereunder, and the Employer or Plan Sponsor agrees to be financially responsible for all expenses related to that transport, Voya Travel Assistance will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if Voya Travel Assistance was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.

D. Voya Travel Assistance shall not be responsible for any claim, damage, loss, cost, liability or expense which arises in whole or in part as a result of Voya Travel Assistance's inability to reach the Employer's or Plan Sponsor's authorized Contact person for any reason beyond Voya Travel Assistance's control, or as a result of the failure and/or refusal of the Employer or Plan Sponsor to authorize services proposed by Voya Travel Assistance.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Products and services may not be available in all states.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

204331-02012019

County of San Joaquin Enrollment/Participation Agreement

Return this form to the Auditor-Controller's Payroll,
44 N. San Joaquin Street, Ste 550, Stockton CA 95202

Fax Number: 209-468-0408

Section A - Plan and Participant Information

Account No **62116-1-1**	Social Security Number	Employer **County of San Joaquin 457b**	Employee ID:	
Participant Name (Last, First, M.I.)			Daytime Phone Number	
Mailing Address	City		State	Zip Code
E-mail	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married	Hire Date	Date of Birth

Section B - Contributions

Elective Deferral Per Pay Period *($10.00 Minimum)*

1. ☐ **BEFORE TAX:** I elect to contribute $ ________ or ________ % of my compensation each payroll period on a before-tax basis.
2. ☐ **AFTER TAX:** I elect to contribute $ ________ or ________ % of my compensation each payroll period on an after-tax basis.
3. ☐ I do not elect to contribute a portion of my salary at this time.

Section C - Investment Elections

Future contributions will be invested in an age-based target investment option. You may select an investment option from the investments made available to your plan. To make any investment elections or changes please visit **www.retiresmart.com or call 1-800-743-5274**.

The employee acknowledges that he or she has had an opportunity to review the important plan disclosures included in the plan welcome/enrollment package previously delivered to the employee, and that important plan disclosure information can also be obtained by contacting MassMutual at 1-800-743-5274 or linking to Account Access from www.retiresmart.com.

Section D - Beneficiary Designation

I designate the following beneficiary(ies) in accordance with the 457(b) Deferred Compensation Plan

Primary Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			PRIMARY TOTAL:	100%

Contingent Beneficiary (optional): If no Primary Beneficiary listed above is alive upon my death, I designate the following person(s) to receive my account balance upon my death: (Must be in whole percentages totaling 100 %.)

Contingent Beneficiary(ies) name, address and phone no.	Social Security (optional)	Date of Birth	Relationship	%
			CONTINGENT TOTAL:	100%

NOTE: If you are married and designate your spouse for less than 100% of your death benefit, you must complete a full Beneficiary Designation/Spousal Consent form. You can obtain this via your payroll department.

NOTE: MassMutual will not display Contingent Beneficiary information on our participant website at www.retiresmart.com. An electronic copy of this form is kept on record.

Section E - Employee Agreement and Signature

If elected above, I authorize that any Before-Tax or After-Tax Contributions indicated above be made by reducing the Employee's net pay. This agreement shall continue in effect while I am employed by the Employer or until it is changed in accordance with the terms of the Plan. I understand that the terms of the Plan may provide the Employer with the authority to reduce or cease my 457(b) contributions to ensure the Plan satisfies the requirements of Section 457(b). The execution and the delivery of this form to the offices of MassMutual revokes all prior beneficiary designations that I have made. I understand that this beneficiary designation will not take effect until it has been received in good order by MassMutual.

_________________________________ Participant Signature

_________________________________ Date

Section F - Important Information

BENEFICIARY INFORMATION

Please complete the Beneficiary Designation including name, address, phone number, Social Security Number, date of birth, relationship and percentage of death benefit. The percent of benefit must total 100% for all primary beneficiaries named. If naming contingent beneficiary(ies) the total percentage for this designation must equal 100%. Married residents of community property states may want to seek legal advice if naming a non-spouse Primary Beneficiary.

Type of Beneficiary:		Examples of Designations:
One Beneficiary		Jane Doe, wife, 100%
Two or more Primary Beneficiaries, equally among the survivors		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% or equally among the survivors
Two or more Primary Beneficiaries, with their share to their children		John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% per stirpes
Primary and Contingent Beneficiaries	either or	Primary: Jane Doe, wife, 100% if living; Contingent: John Doe, son, 33% Carol Smith, daughter, 33% Mark Doe, son 34% equally among the survivors per stirpes
Participant’s Estate		Participant’s Estate
Trustee		Jane Doe, trustee under trust agreement* dated...

* Date of the execution of the trust agreement or a copy of the trust agreement must be provided.

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • contactus@sjcera.org • www.sjcera.org

BENEFICIARY DESIGNATION

Please type or print in ink. Please refer to the instructions for this form if you have any questions or contact our office.

MEMBER

First Name	Middle Name	Last Name
Mailing Address		CAPS (Employee) ID Number
City	State / Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number	Social Security Number
E-Mail Address		○ Male ○ Female ○ Single ○ Married

PRIMARY BENEFICIARIES

I hereby designate the following person(s) who survive me as beneficiaries for death benefits under the County Employees' Retirement Law of 1937 in the event of my death. I understand that if I die after becoming eligible for service retirement, this beneficiary designation may be superceded in certain cases and benefits paid according to law to my eligible surviving spouse or minor children; or, if my death is determined to be service connected, special death benefits will be paid in the manner prescribed by law. If no percentage (%) share is designated, benefits will be paid share and share alike.

#					
1	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
2	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %
3	Name First Middle Last			Social Security Number	
	Mailing Address			Relationship to Member	Date of Birth
	City	State	Zip Code	Telephone	Percent Share %

If you wish to designate additional primary beneficiaries, please list their name(s), address(es), SSN(s) and relationship(s) to you and share(s) on a separate piece of paper and attach it to this form. ☐ Additional beneficiaries listed on attached.

SIGNATURE

By this beneficiary designation, I hereby revoke any previous designation I have filed. I understand that my marriage, initiation of dissolution or annulment of my marriage, or the birth or adoption of a child subsequent to the date I execute this form may void this designation.

Member Signature	Date	Witness Signature (cannot be a beneficiary)	Date
By signing the beneficiary designation form, I acknowledge the information entered by my spouse. Spouse Signature:	Date	Print Witness Name	

☐ I certify under penalty of perjury that I am not currently legally married (e.g., divorced, widowed, or never married)

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 • Stockton, CA 95202 • (209) 468-2163 • (209) 468-0480 Fax • www.sjcera.org

DESIGNATION OF BENEFICIARY

The Basic Death Benefit payable by the SJCERA upon the death of a member prior to retirement consists of the member's accumulated contributions and interest, plus up to six months of the member's final average monthly salary, depending on the years of retirement service credit. This benefit is also referred to as the "lump sum death benefit." The member's surviving spouse or minor children may be eligible for other benefits in lieu of the Basic Death Benefit. These other benefits are also referred to as "survivor continuance." Please refer to the SJCERA Retirement Plan Information booklet for further details concerning pre-retirement death benefits.

Please complete the Beneficiary Designation (Form 110) to designate a beneficiary or beneficiaries to receive the lump sum death benefit payable from the SJCERA in the event of your death prior to retirement.

- You may designate any person(s) or your estate as beneficiaries.
- You may designate a minor child as your beneficiary. **Do not** name a guardian of the minor child in addition to, or instead of, the minor child. If benefits are payable to a minor child, the court-appointed guardian will be responsible for any benefits paid to the child. (Note: A parent who has custody of a minor child is not required to be appointed by the court as a guardian in order to claim a benefit on behalf of that child.)
- You may designate a trust as your beneficiary. However, if you wish to designate a trust, the following information should be provided: The name of the trust, date of trust and name/address of the person with whom the trust is on file.

Also, unless you specify otherwise, the beneficiary you designate on Form 110 will also be the beneficary for any group life insurance benefits provided by your employer (San Joaquin County) for which you may be eligible.

INSTRUCTIONS FOR COMPLETING FORM 110

1. MEMBER INFORMATION

a. Enter your full legal name (no middle initials), social security number, date of birth, current mailing address, and home and work telephone numbers.

b. Enter your e-mail address if you have one. This is voluntary and your e-mail address will remain confidential with the SJCERA.

c. Fill-in the appropriate bubble to specify your gender and current marital status.

2. PRIMARY BENEFICIARIES

Use this section of the form to designate the beneficiary or beneficiaries who are to receive the lump sum death benefit benefit payable from the SCJERA in the event of your death prior to retirement. **If you are legally married and designate someone other than your spouse as your beneficiary, your spouse may still be entitled to his/her community property interest in the lump sum and/or survivor continuance death benefits.**

For each primary beneficiary, you must designate:

a. Full first, middle and last name, Social Security number, complete mailing address, birthdate, and relationship to you.

b. If you designate more than one beneficiary, designate the percentage share to be distributed to each beneficiary. The total of all shares listed must equal 100%.

Example A: If you have two beneficiaries listed and you would like each of them to receieve half of your lump sum death benefit, enter "50" for each beneficiary in the "Percentage Share" box.

Example: B: If you designate only one primary beneficiary, enter "100" in the "Percentage Share" box.

(CONTINUED NEXT PAGE)

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INSTRUCTIONS FOR COMPLETING FORM 110 - CONTINUED

c. If you want to designate more than three primary beneficiaries, please **ATTACH a separate piece of paper** listing your additional beneficiaries and include all of the same information required. Please write your name and Social Security number at the top of any attached page(s). Fill in the bubble for "Additional beneficiaries listed on attached".

NOTE: ALL primary beneficiaries will be <u>concurrent,</u> rather than successive or contingent, payees.

3. SIGNATURE

a. You must sign and date the form in the presence of a witness (other than a named beneficiary) using your full first, middle, and last name. (Example: John Edward Smith.) An unsigned form is not valid and will be returned to you.

b. If you are married, your spouse must sign and date the form, in the presence of a witness, to acknowledge the names of the beneficiaries you are designating.

c. Have the witness clearly sign and date the form.

NOTE: IF YOU ARE UNABLE TO OBTAIN YOUR SPOUSE'S SIGNATURE, YOU MUST COMPLETE AND RETURN THE JUSTIFICATION FOR NON SIGNATURE OF SPOUSE (FORM 112).

4. SUBMIT FORM

Submit the completed, signed, and witnessed Beneficiary Designation form to the SJCERA via U.S. mail, inter-office mail, or in person to the address shown at the top of the Beneficiary Designation Form. If required, also submit completed Justification for Non Signature of Spouse (Form 112).

IMPORTANT NOTICE

Your Beneficiary Designation may be revoked automatically if any of the following events occur subsequent to the date you execute and submit this Beneficiary Designation form:

a. Marriage; or
b. Dissolution or annulment of marriage **if effected <u>after</u>** the Beneficiary Designation form was submitted; or
c. Birth or adoption of a child; or
d. Termination of employment and withdrawal of your contributions from the SJCERA.

If your beneficiary designation is revoked by one of the above events, benefits will be paid to your statutory beneficiaries (pursuant to the California Probate Code), unless you submit a new Beneficiary Designation to SJCERA. You may request a blank form from SJCERA or download it from our web site at www.sjcera.org.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLETING AND SUBMITTING THIS FORM, PLEASE CONTACT THE SJCERA AT 209-468-2163.

San Joaquin County Employees' Retirement Association
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JUSTIFICATION FOR NON-SIGNATURE OF SPOUSE

If you are legally married and your spouse's signature does not appear on your SJCERA Beneficiary Designation (Form 110), you **MUST** complete and sign this form and submit it with your Beneficiary Designation. Your Beneficiary Designation will not be accepted by the SJCERA without this Justification for Non-Signature of Spouse.

MEMBER

First Name	Middle Name		Last Name
Mailing Address			Social Security Number
City	State	Zip Code	Date of Birth
Home Telephone Number	Work Telephone Number		○ Male ○ Female
E-Mail Address			

JUSTIFICATION FOR NON SIGNATURE

I am married, but my legal spouse did not sign my SJCERA Beneficiary Designation (Form 110) because either (check **ONLY ONE** of the following):

- ☐ I do not know the whereabouts of my spouse and I have undertaken all reasonable steps necessary to locate my spouse without success; **OR**
- ☐ My spouse has been advised of the application and has refused to sign the written acknowledgement; **OR**
- ☐ My spouse is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**
- ☐ My spouse has no identifiable community property interest in the benefit; **OR**
- ☐ My spouse and I have executed a marriage settlement agreement which makes the community property law inapplicable to the marriage.

SIGNATURE

I certify under penalty of perjury that the foregoing information is true and correct.

Member Signature	Date

San Joaquin County Employees' Retirement Association
6 S. El Dorado Street, Suite 400 Stockton, CA 95202 • (209) 468-2163 • ContactUs@sjcera.org

Membership Certification

Complete and **return this form to your Personnel Office within 3 business days of your start date. Attach a copy of your birth certificate or valid passport**. If you do not have a birth certificate or valid passport, or are unable to obtain one, see the **Age Verification Policy** on www.sjcera.org for other acceptable documents.

1. Member Information

First Name	MI	Last Name	Cell Phone

SSN	Date of Birth	Employee ID Number

2. Previous Employment & Reciprocity

*Previous employment information is needed to determine tier, contribution rate, and eligibility for reciprocity. Reciprocity allows members to move from one eligible government retirement system to another and retain valuable retirement benefits. (**See instructions on back**)*

Most Recent Previous Employer	Retirement System (Refer to list of systems on the back)
Last Date of Employment (under most recent reciprocal retirement system)	**First Membership Date** (in any previous reciprocal retirement system)

Check applicable statement:	Payroll Use
☐ I have not been an active member of another reciprocal California government retirement system within the last six months. (Active members are generally permanent full-time employees. See list of retirement systems on back.)	Tier 2
☐ I retired from ______________________________ retirement system and subsequently began full-time employment with an SJCERA-participating employer.	Tier 2
☐ I was a member of the ______________________________ retirement system and, within six months, subsequently began full-time employment with a SJCERA-participating employer.	--
☐ My reciprocal system membership began before Jan. 1, 2013 and I left my member contributions on deposit with that retirement system.	Tier 1
☐ My reciprocal system membership began on/after Jan. 1, 2013 or I withdrew (refunded) my member contributions from that retirement system	Tier 2

3. Acknowledgement

I have read this form and its instructions in their entirety. I hereby certify that the foregoing information is true and correct. I understand that incorrect information may require corrections to my SJCERA account including, but not limited to, my membership date, tier and contribution rate. I authorize SJCERA to establish reciprocity if I am eligible and make any necessary corrections to my account including collecting additional contributions if owed.

EMPLOYEE SIGNATURE	DATE

4. Employer Certification *(See instruction on back)*

Employing Agency/Department	New Employee's Job Class Title	Employee Hire Date

Employer Designee (signature)	Designee Title	Date

Employee Instructions

Complete and submit this form with a copy of your birth certificate or other proof-of-age documents to your Personnel Office within 3 business days of beginning employment. For more information, visit www.sjcera.org or call 209.468.2163.

Section 2 Instructions: Previous Employment and Reciprocity Information

Your prior public plan benefit information is required to correctly determine your Tier and contribution rate.

Previous Employment with a SJCERA-employer

If you are a Tier 1 member whose contributions remained on deposit with SJCERA when you left SJCERA-covered employment, and you return to a full-time permanent position with the same SJCERA employer within six months, you will retain your previous SJCERA entry age and contribution rate. If you return to the same employer in more than six months, your entry age and contribution rate will be based on your age at reentry into membership. If you return to a different SJCERA-employer after more than six months, you will be placed in Tier 2.

SJCERA Employers		
San Joaquin County	Mountain House Community Svcs. Dist.	SJC Mosquito & Vector Control
Lathrop-Manteca Fire District	SJC Historical Society & Museum	SJC Superior Court
SJC Law Library	Tracy Public Cemetery	Waterloo-Morada Fire District

Previous Employment with another California Government Employer (Reciprocity)

If you were a member of a reciprocal California government retirement system (see list below) within the last six months, reciprocity allows you to link your entry age, service credit and highest average compensation across all your reciprocal systems. Reciprocity may also allow you enter SJCERA as a Tier 1 member, which offers a higher benefit formula.

Reciprocal Retirement Systems				
County Retirement Systems				
Alameda	Kern	Merced	San Diego	Sonoma
Contra Costa	Los Angeles	Orange	San Joaquin	Stanislaus
Fresno	Marin	Sacramento	San Mateo	Tulare
Imperial	Mendocino	San Bernardino	Santa Barbara	Ventura
State Retirement Systems				
CalPERS (California Public Employees Retirement System)	CalSTRS (California State Teachers' Retirement System)	Legislators' Retirement System (LRS)	Judges Retirement System (JRS)	

Tiers

Tier 1 Members: Employees who entered SJCERA membership before January 1, 2013, or who establish incoming reciprocity based on eligible reciprocal system membership before January 1, 2013.

Tier 2 Members: Employees who enter SJCERA membership on or after January 1, 2013; Tier 1 members who terminate and return to a different SJCERA-participating employer after more than six months; SJCERA retirees who return to active membership.

Employer Instructions

1. Collect this *Membership Certification* form from all new or returning full-time benefited employees, verify the date of birth is entered correctly and complete the Employer Certification section.
2. Submit the following completed forms and documents directly to SJCERA within the first week of employment:
   - ☐ Member Certification
     - ☐ Copy of the employee's Birth Certificate, valid U.S. Passport or valid California Real I.D. Card
       See the Age Verification Policy on www.sjcera.org for other acceptable documents.
   - ☐ Beneficiary Designation
   - ☐ Safety Only – Social Security Form SSA-1945 (if applicable)

Congratulations San Joaquin County New Hire!

Chimienti & Associates Insurance Services manages the Voluntary Insurance Plans for the County. Please take a moment to review these very important plans that are part of your Employee Benefits Package with San Joaquin County:

Whole Life *with Colonial*

- Permanent Life Insurance with locked in rates Family coverage available. Fully portable.

Term Life *with Colonial*

- Term Life options are available for 10, 20 and 30 year periods.

Cancer Plan *with Colonial*

- Helps with the out-of-pocket expenses that can be incurred if you are diagnosed with cancer. Also includes a Health Screening Benefit. Family coverage available.

Critical Illness Plan *with Colonial*

- Pays a lump sum benefit directly to you in the event of a covered Critical Illness. Also includes a Health Screening Benefit. Family coverage available.

Universal Life *with Transamerica*

- Life insurance with cash build up Locked-In rates. Family coverage available. Fully portable.

Please call Chimienti & Associates at (877) 733-1670 if you would like additional information regarding the above benefits or are interested in enrolling. A benefits counselor will be happy to answer any questions that you may have.

Plan Year
7/1/2021 - 6/30/2022

Gaby Hemphill
District Manager
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AMERICAN FIDELITY
a different opinion

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

New Career, New Choices

Starting a new job can be overwhelming, and your insurance options can be confusing. What you select may be one of the most important things you do this year.

Get help with your options. Stop by and see an American Fidelity account manager.

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Disability Income Insurance

AF™ **Disability Income Insurance**

- can help protect your finances in case of a covered injury or illness
- provides a benefit to help cover costs while you are unable to work
- pays some of your gross monthly earnings

americanfidelity.com/info/disability

Hospital Indemnity Insurance

AF™ **Limited Benefit Hospital Indemnity Insurance**

- helps pay for out-of-pocket costs, like a hospital stay
- when used with a Health Savings Account allows for a tax benefit and potential savings

americanfidelity.com/info/hospital-indemnity

Approximately **every 40 seconds**, an American will suffer a heart attack.

American Heart Association: Heart Disease and Stroke Statistics 2019 At-a-Glance, pg. 2 February 2019.