

COUNTY OF SANTA CLARA BENEFIT ENROLLMENT & CHANGE FORM

EE Name: _____ SSN: _____ EMPID: _____

NEW (check one) <input type="checkbox"/> Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other: _____	CHANGE (Check all that apply) <input type="checkbox"/> Add a Dependent <input type="checkbox"/> Remove a Dependent <input type="checkbox"/> Beneficiary <input type="checkbox"/> Cancel Optional Plan <input type="checkbox"/> AD/D Plan <input type="checkbox"/> Other: _____
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Medical Plan – Check Only One

Kaiser Valley Health Plan (Requires VHP form) Health Net Medical Plan (requires Health Net form)

Dental Plan – Check Only One

Delta Dental Pacific Union Dental (requires PUD form)

Note: Enrollment in the Vision Services Plan is automatic when a Medical & Dental Plan is chosen.

OR

Bonus Waiver Program
(requires Bonus Waiver Program form, complete this form for dental and life/optional insurances only)

DEPENDENT ENROLLMENT INFORMATION

I wish to enroll my dependents in the following (check one):

Medical, Dental & Vision Dental & Vision Only Medical Only

Name:	Relationship	Status	Birth date	SSN
	<input type="radio"/> Wife <input type="radio"/> Husband <input type="radio"/> SS Domestic Partner	Date of Marriage/Divorce / /		
	<input type="radio"/> Son <input type="radio"/> Daughter	Student? <input type="radio"/> Yes <input type="radio"/> No		
	<input type="radio"/> Son <input type="radio"/> Daughter	Student? <input type="radio"/> Yes <input type="radio"/> No		
	<input type="radio"/> Son <input type="radio"/> Daughter	Student? <input type="radio"/> Yes <input type="radio"/> No		

Attach a separate piece of paper if you need more space to list eligible dependents

Basic Life & Optional Coverages – Check all that Apply

See Reverse Side for Additional Space

Basic Life Insurance: Enrollment is automatic when a Medical & Dental Plan is chosen. Please indicate Beneficiaries.

Benef. Name: _____ Relationship: _____ Percent: _____

Benef. Name: _____ Relationship: _____ Percent: _____

Supplemental Life: Enrollment beyond 30 days of your hire date will require Evidence of Insurability. Check One.

Benefit Amount Based On Salary OR Fixed Benefit Amount: \$ _____

If Beneficiary is the same as Basic Life – Check here If not the same, please indicate below.

Benef. Name: _____ Relationship: _____ Percent: _____

Accidental Death & Dismemberment: You may enroll in this plan at any time without restriction.

Benefit Amount: \$ _____ Single OR Family (check only one)

If Beneficiary is the same as Basic Life – Check here If not the same, please indicate below.

Benef. Name: _____ Relationship: _____ Percent: _____

Long Term Disability: Enrollment beyond 60 days of your hire date will require Evidence of Insurability. Check One.

Benefit Amount Based On Salary OR Fixed Benefit Amount: \$ _____

ADDITIONAL INFORMATION: Should you need additional space for dependents and/or beneficiaries, complete this section.

<u>Additional Beneficiaries</u>				
<u>Basic Life Insurance:</u>				
Benef. Name:		Relationship:		Percent:
Benef. Name:		Relationship:		Percent:
<u>Supplemental Life:</u>				
Benef. Name:		Relationship:		Percent:
<u>Accidental Death & Dismemberment:</u>				
Benef. Name:		Relationship:		Percent:

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT:

I understand that (except for Small Claims Court cases, claims subject to Medicare appeals procedure, and, if my Group must comply with ERISA, 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 by 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.

BIWEEKLY COSTS: Costs vary depending on whether you are full-time or part-time and the elections you have made. See your Employee Service Center Representative for the current rates and premiums.

SUPPLEMENTAL LIFE and LONG TERM DISABILITY: If you did not enroll in these plans at the time you were hired and wish to enroll now or make changes to your current benefit level (other than canceling), you must complete the appropriate documents to provide Evidence of Insurability. See your Service Center Representative for these forms.

ADDRESS CHANGES: With the exception of Valley Health, Pacific Union Dental, and the Deferred Compensation Plan, address changes will be reported to all plan providers electronically. You must complete the individual plan forms for VHP, PUD or the Deferred Compensation Program in order to notify these providers of a new address.

If I am enrolling eligible members on my medical and dental plan coverage, I have completed the County's Affidavit of Marriage or Affidavit of Same-Sex Domestic Partnership.

I certify that all the information contained in this form is true and correct. I understand that I should confirm my effective date of coverage through my Departmental Employee Service Center for benefit enrollment or change prior to seeking services from any insurance provider. The County of Santa Clara is not responsible for services received prior to the effective date of coverage.

Employee Signature: _____ Date: _____

Official Use Only – Do not Write Below This Line

Coverage Begin Date: _____ Deduction Begin Date: _____ Initials: _____

c: Original – Departmental Employee Service Center

Copy – Employee