EMPLOYEE BENEFITS ENROLLMENT & CHANGE FORM
COUNTY OF SANTA CLARA

Official Use Only—Do Not Write In This Box

Coverage Begin Date: __________ Deduction Begin Date: ___________ Processed by:___________ Medical Group#:___________

Last Name:	First Name:	Middle Initial:

Street Address: ________________________________ SSN: _______________________ EE ID#: ______________________

City: _________________ State: _____ Zip: ______ Date of Birth: _________________ Gender: ______________________

Home Phone: ________________________________

Cell Phone: ________________________________

Work Phone: ________________________________

Email: ________________________________

Marital Status: *(Check one only)*

○ Single ○ Married ○ Divorced

○ Separated ○ Widowed

○ Domestic Partnership

Ethnicity (Optional): _____________

Race (Optional): _____________

Preferred Written Language:

____

NEW *(Check all that apply)*

☐ New Hire (Full-Time)

☐ New Hire (Part-Time)

☐ Open Enrollment

☐ Dual Coverage*

☐ Special Enrollment Period**

CHANGE *(Check and circle all that apply)*

☐ Add a Dependent

☐ Remove a Dependent

☐ Change Beneficiary

☐ Address Change

☐ Change Current Plan Election

☐ Add/Change/Remove Voluntary Life

☐ Add/Change/Remove Voluntary AD&D

☐ Add/Change/Remove Voluntary LTD

☐ Other: ________________________________

*If you checked Dual Coverage above, please complete the Dual Coverage Form.

**Special Enrollment Period (due to marriage, newborn, adoption, legal guardianship, court order and/or assumption of parent-child relationship) Qualifying Event Date: _______________ Qualifying Reason: ______________________________

Medical Plan *(Check one plan type only)*

Kaiser Permanente

○ HMO

Health Net

○ POS

Valley Health Plan

○ Classic ○ Preferred (Extra Help Only)

☐ Bonus Waiver Program *(requires Bonus Waiver Program form (Ben-04) and proof of other coverage; those participating are eligible to enroll in dental, vision, life and optional insurances; complete the following sections as applicable.)*

SUBSCRIBER'S PHYSICIAN INFORMATION

Participating Physician Group: ______________________ Primary Care Provider: ________________________________

PPG/PCP Enrollment ID Number: ____ Is this your current PCP? ○ Yes ○ No

Please note: If you enroll in a Health Net or VHP plan and you do not select a PPG or a PCP, one will be selected for you. If you are enrolling dependents and their physician information is different from what is listed above, please provide the additional physician information on the next page.

Dental Plan *(Check one only)* ○ **Delta Dental** ○ **Liberty Dental** ○ **Waive Plan Option** *(for Part-Time employees)*

Vision Plan *(Check one for Part-Time employees)* ○ **VSP** ○ **Waive Plan Option**

Please note: Enrollment in the Vision Services Plan is automatic when both a Medical & Dental Plan is selected for eligible employees and dependents.

Declination of Medical Coverage

Complete this section if you or your dependents are declining medical coverage.

Declining Medical Coverage for: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Dependent(s)

Name(s): ____

Reason: ☐ Other Group Coverage through this Employer ☐ Individual Coverage ☐ Other:______________________

☐ Other Group Coverage by Another Group (i.e., spouse's employer)

IF YOU ARE DECLINING MEDICAL COVERAGE, STOP AND READ CAREFULLY:

I have decided to decline medical coverage for myself and/or my dependent(s). I acknowledge that my dependents and I may have to wait to be enrolled until the next Annual Open Enrollment Period or Special Enrollment Period due to a qualifying event. The available coverages have been explained to me by my employer and I've been given the chance to apply for available coverages. Additionally, by signing below, I certify that the reason I decline coverage is accurate as indicated by the checkmarks above.

Employee: ______________________________ Date: ______________

(Sign only if declining coverage. If signed in error, please cross out and initial.)

DEPENDENT ENROLLMENT INFORMATION

(Attach applicable documentation: marriage certificate, domestic partner registration, or birth certificate)

Name: ______________________________

Relationship: *(Check one only)*

○ Spouse ○ Eligible Domestic Partner

Medical, Dental & Vision: ○ Enroll ○ Remove

Dental & Vision Only: ○ Enroll ○ Remove

Medical Only: ○ Enroll ○ Remove

Address: ☐ *(Check here if same as subscriber)*

Street: ______________________________

City: ____________ State: _____ Zip: ________

Phone Number: ______________________________

Email (Optional): ______________________________

Marriage/Divorce/Term Date: ______________________

Date of Birth: __________ Gender: ____________

Ethnicity (Optional): ________ Race (Optional): ________

SSN: __________ Preferred Language: ____________

Disabled? ○ Yes ○ No Other Health Coverage?* ○ Yes ○ No

Participating Physician Group: ____________________

Primary Care Provder: ____________________

PPG/PCP Enrollment ID Number: ____________________

Is this your current PCP? ○ Yes ○ No

Name: ______________________________

Relationship: *(Check one only)*

○ Son ○ Daughter ○ Other: ____________

Medical, Dental & Vision: ○ Enroll ○ Remove

Dental & Vision Only: ○ Enroll ○ Remove

Medical Only: ○ Enroll ○ Remove

Address: ☐ *(Check here if same as subscriber)*

Street: ______________________________

City: ____________ State: _____ Zip: ________

Phone Number: ______________________________

Email (Optional): ______________________________

Date of Birth: __________ Gender: ____________

Ethnicity (Optional): ________ Race (Optional): ________

SSN: __________ Preferred Language: ____________

Disabled? ○ Yes ○ No

Other Health Coverage?* ○ Yes ○ No

Participating Physician Group: ____________________

Primary Care Provder: ____________________

PPG/PCP Enrollment ID Number: ____________________

Is this your current PCP? ○ Yes ○ No

Name: ______________________________

Relationship: *(Check one only)*

○ Son ○ Daughter ○ Other: ____________

Medical, Dental & Vision: ○ Enroll ○ Remove

Dental & Vision Only: ○ Enroll ○ Remove

Medical Only: ○ Enroll ○ Remove

Address: ☐ *(Check here if same as subscriber)*

Street: ______________________________

City: ____________ State: _____ Zip: ________

Phone Number: ______________________________

Email (Optional): ______________________________

Date of Birth: __________ Gender: ____________

Ethnicity (Optional): ________ Race (Optional): ________

SSN: __________ Preferred Language: ____________

Disabled? ○ Yes ○ No

Other Health Coverage?* ○ Yes ○ No

Participating Physician Group: ____________________

Primary Care Provder: ____________________

PPG/PCP Enrollment ID Number: ____________________

Is this your current PCP? ○ Yes ○ No

Name: ______________________________

Relationship: *(Check one only)*

○ Son ○ Daughter ○ Other: ____________

Medical, Dental & Vision: ○ Enroll ○ Remove

Dental & Vision Only: ○ Enroll ○ Remove

Medical Only: ○ Enroll ○ Remove

Address: ☐ *(Check here if same as subscriber)*

Street: ______________________________

City: ____________ State: _____ Zip: ________

Phone Number: ______________________________

Email (Optional): ______________________________

Date of Birth: __________ Gender: ____________

Ethnicity (Optional): ________ Race (Optional): ________

SSN: __________ Preferred Language: ____________

Disabled? ○ Yes ○ No

Other Health Coverage?* ○ Yes ○ No

Participating Physician Group: ____________________

Primary Care Provder: ____________________

PPG/PCP Enrollment ID Number: ____________________

Is this your current PCP? ○ Yes ○ No

BASIC LIFE & OPTIONAL COVERAGE *(Check all that apply)*
(Additional Space for Beneficiaries Below)

Basic Life Insurance: *(Enrollment is automatic. Please indicate beneficiaries below.)*
☐ Waive Plan Option (for Part-Time employees)

☐ **Voluntary Additional Life:** Enrollment beyond 31 days of your hire date will require Evidence of Insurability.

☐ Benefit Amount Based on Salary **OR** ☐ Fixed Benefit Amount: $ ____________ ☐ Beneficiary is the same as Basic Life

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

☐ Benefit Amount: $ ________________ Coverage Type: ○ Single **OR** ○ Family ☐ Beneficiary is the same as Basic Life

Special Notice Regarding Beneficiaries: California is a community property state, and your spouse may claim a community property interest in your benefits, which may affect the rights to benefits of the beneficiary(ies) you have designated. You should consult with an attorney if you wish legal advice regarding community property laws in effect and how they apply to the distribution of your benefits.

☐ **Long-Term Disability:** Enrollment beyond 31 days of your hire date will require Evidence of Insurability. *(Check only one.)*

○ Benefit Amount Based on Salary **OR** ○ Fixed Benefit Amount: $________________

BENEFICIARIES: *(Complete this section.)*

Basic Life Insurance

Beneficiary Name	Relationship	SSN	Designation	Percent
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	

Voluntary Additional Life

Beneficiary Name	Relationship	SSN	Designation	Percent
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	

Voluntary Accidental Death & Dismemberment

Beneficiary Name	Relationship	SSN	Designation	Percent
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	
			○ Primary ○ Contingent	

Read and sign if selecting a Kaiser Permanente medical plan:

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our 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.

Signature Required for all Kaiser Permanente Plans: ___________________________________ Date:________________

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

Read and sign if selecting a Valley Health Plan medical plan:

VALLEY HEALTH PLAN ACKNOWLEDGEMENTS AND SIGNATURE:

In completing this Valley Health Plan application for myself and eligible dependents, I acknowledge the following:

1. I am obligated to understand and abide by the terms, conditions and provisions of the Plan Contract (Group Service Agreement) and the current VHP Evidence of Coverage & Disclosure Form (Member Handbook).
2. Except in the case of an emergency or prior authorized services, VHP requires me to obtain all Covered Services from VHP Network Providers/Facilities.
3. I have read and understand the terms of this application. My signature on this application indicates that the information is accurate and correct. I accept these terms.

Employee Signature: ____ Date:_________________________

Read and sign if selecting a Health Net medical plan:

ACCEPTANCE OF COVERAGE (signature required): California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

HEALTH NET BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Employee Signature: ____ Date: _______________________________

(Sign only if accepting Health Net coverage. If signed in error, please cross out and initial.)

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.

VOLUNTARY 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 the Deferred Compensation Plan, address changes will be reported to all plan providers electronically. You must complete the individual plan forms for the Deferred Compensation Program in order to notify these providers of a new address.

GENERAL INFORMATION FOR VHP: Please complete this Benefits Enrollment & Change Form accurately. If you have any questions about your coverage or completing this form, contact your employer or Valley Health Plan (VHP). Your new or revised VHP identification card will be mailed to your address in VHP's file. Contact your employer to ensure your VHP membership records are updated. If you do not select a participating Primary Care Physician (PCP) for yourself and each of your eligible dependents, a PCP will be selected for you. Your eligible dependent may be covered up to age 26. Please check with your employer to see if your dependent qualifies.

BENEFIT(S) ELECTION ACKNOWLEDGMENT: If I am enrolling dependents on my medical, dental and/or vision plan coverage, I certify that these dependents are eligible according to the County's eligibility rules and I have attached applicable documentation, such as a marriage certificate, domestic partner registration certificate and/or birth certificate.

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. I further understand that I must notify the County within 30 days if any of my dependents become ineligible for coverage. Failure to notify the County or to falsify this document or any other benefit document could constitute fraud and may result in discipline, including, but not limited to, reimbursing the County for any premiums paid for ineligible dependents, disenrollment from the benefits elected, denial of claims payment, termination of employment, and/or criminal and/or civil prosecution.

I understand that most benefits under the County's Plan are provided pre-tax. I understand that in accordance with Internal Revenue Code regulations, the benefits that I elect must remain in force for the entire Plan Year, and that I may not make a change in my benefits coverage or contributions during the Plan Year unless there is a qualified mid-year change as defined by the Plan and in accordance with Internal Revenue Code regulations.

SALARY REDUCTION AUTHORIZATION: I understand that with my signature below, I am authorizing my employer (the County) to deduct from my paycheck the contributions for group benefits for which I am eligible and/or have elected on this form.

Employee Signature: ______________________________ **Date:** ________________

Valley Health Plan:

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call right away at 1.888.421.8444 (toll-free).

IMPORTANTE: ¿Puede leer esta documento? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta documento escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1.888.421.8444(número gratuito).

QUAN TRQNG: Quý vị có đọc được taì liệu không? Nếu không,chúng tôi có thể nhồ ngưồi giup quý vị đọc thư. Quý vị cũng có thể nhận taì liệu này bằng tiếng Việt. Để được giúp đoỡ miễn phí, xin gọi ngay số 1.888.421.8444 (miễn phí).

GENERAL STATEMENT OF NON-DISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The County of Santa Clara complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The County does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The County:

a. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b. Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact the Employee Services Agency at 408-299-5880.

If you believe that the County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can report your complaint to the County's Equal Opportunity Department (EOD), 2310 North First Street, Suite 101, San Jose CA 95131; telephone: (408) 993-4840; email: EOD@ceo.sccgov.org. You can file a complaint in person or by mail, fax, or email. If you need help filing or reporting a complaint, EOD is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 408-299-5880
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 408-299-5880
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 408-299-5880
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 408-299-5880
Persian (Farsi)	تماس بگیرید. توجه: اگر به‌زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 408-299-5880
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 408-299-5880 पर कॉल करें।
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 408-299-5880
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 408-299-5880
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 408-299-5880 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 408-299-5880
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 408-299-5880
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。408-299-5880まで、お電話にてご連絡ください。
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 408-299-5880
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 408-299-5880។
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 408-299-5880 'ਤੇ ਕਾਲ ਕਰੋ।