CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Human Resources
2020 Enrollment Change Form

Print or type clearly. Completed, signed requests must be sent to: Human Resources – Employee Benefits, 4th Floor Tower-City Hall, Fax to: (408) 999-0862, or Email to: HRBenefits@sanjoseca.gov

Last Name	First Name	Employee ID

If you have recently changed your address, you must log-in to eWay and update your address. Your new address will be sent to the benefit providers on the first pay period of the next month.

Qualifying Life Event for the change in coverage: The new Plan Option(s) will need to be made on Page 2 (including the New Coverage Level and whether adding or dropping dependents).

Enrolling in coverage, adding a dependent(s), or canceling/waiving coverage (check all that apply): In order to request a change in coverage, the qualifying life event must have occurred in the last 30 days. If the form is received within 30 days of the qualifying life event, the change will be effective the first of the month following the qualifying life event.

- ☐ Change in job or benefit status (e.g., due to return from leave of absence, new hire, reduction of hours, etc.)
  Provide reason and effective date: _____
- ☐ Marriage (must attach a copy of marriage certificate and, if applicable, complete the Request to Provide Dependent Coverage section on page 3).
- ☐ Domestic Partnership established (must attach the completed Affidavit of Domestic Partnership).
- ☐ Adding a new child because of birth, adoption, marriage, guardianship, etc. (must attach a copy of birth certificate and/or court paperwork, if applicable, and complete the Request to Provide Dependent Coverage section on page 3).
- ☐ Re-enrolling a child age 19-23 on benefits due to the child becoming a full time student (must provide a current school schedule with date classes began and the number of units).
- ☐ Lost alternate coverage (must provide proof of the type of coverage lost including the coverage end date).
- ☐ Began unpaid leave of absence. Effective date: _____
- ☐ Gained new alternate group coverage (must provide documentation of the type of coverage gained and effective date).

Dropping dependent from coverage (check all that apply): The following terminations will be effective the first day of the month following the date the dependent is no longer eligible. If you DO NOT notify HR to terminate an ineligible dependent within 30 days of the qualifying life event, you will be responsible for reimbursing the City for any premiums paid on your behalf for the period of time the ineligible dependent was covered.

- ☐ Divorce (must attach a copy of court document). Date of dissolution: _____
- ☐ Dissolution of Domestic Partnership (must attach copy of court document). Date of dissolution: _____
- ☐ Dependent gained alternate coverage (must provide proof of the type of coverage gained and effective date).
- ☐ Child dependent is no longer eligible due to student status or marriage (not applicable for medical plans for dependents under age 26 or disabled). Provide reason and date of event: _____
- ☐ Death of dependent (must attach a copy of the death certificate). Date of death: _____

For COBRA purposes, please provide a valid address for the dropped dependent(s):

_____

I authorize the cancellation of the following benefit(s):

- ☐ Long Term Disability (LTD). To re-enroll, you must provide evidence of insurability (EOI) to Standard Insurance for approval.
- ☐ Personal Accident Insurance (Cigna-AD&D).

Additional Life and Dependent Life Insurance: For changes to the Life Insurance coverage, you must go to the Standard's online portal https://standard.benselect.com/sanjoseca. If you forgot your User Name and/or Password, email EnrollmentSystemsTeam@standard.com.

This box to be filled out by City of San José HR only **Completed by HR Benefits Staff:** _____ **Date:** _____

QE Date: _____ **Coverage Eff. Date:** _____ **Retro Enrollment? Y / N** **Premium Adjustment Required? Y / N** ☐ **Waive EAP**

Comments:

Medical Plan Options:

Kaiser Permanente: ☐ **HMO $25 Copay Plan** ☐ **HMO $1,500 Deductible Plan** (N/A to POA or IAFF) ☐ **HSA $3,000 Deductible Plan** **Anthem Blue Cross:** ☐ **$20 Copay Select HMO Plan*** ☐ **$1,500 Deductible Select HMO Plan*** **Anthem Provider ID#:* _____ ☐ **$100 Deductible Select PPO Plan** ☐ **$100 Deductible Classic PPO Plan** ☐ **$2,500 Deductible Classic PPO Plan w/HSA** ☐ **$2,500 Deductible Classic PPO Plan w/no HSA** **Other:** ☐ **Health In-Lieu Plan** (Proof of alternate group coverage is required for all dependents within 30 days of enrollment and annually.)	**New Coverage Level:** (For all EEs except POA & IAFF) ☐ **Employee Only** ☐ **Employee + Spouse/DP** ☐ **Employee + Child(ren)** ☐ **Employee + Spouse/DP + Child(ren)** **New Coverage Level:** (For POA & IAFF) ☐ **Employee Only** ☐ **Employee + Eligible Dependents**	**Adding dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)** **Dropping dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)**
☐ **Waive Medical** (Employees with alternate healthcare that is not group coverage or part time employees are required to sign the Waiver of Healthcare Acknowledgment on page 4.)		

Dental Options:

Delta Dental ☐ **Delta Dental PPO Plan** ☐ **DeltaCare HMO Plan*** **DeltaCare Provider #*_____ ☐ **Dental In-Lieu Plan** (Proof of alternate group coverage is required for all dependents within 30 days of enrollment and annually.)	**New Coverage Level:** (For all EEs except POA & IAFF) ☐ **Employee Only** ☐ **Employee + Spouse/DP** ☐ **Employee + Child(ren)** ☐ **Employee + Spouse/DP + Child(ren)** **New Coverage Level:** (For POA & IAFF) ☐ **Employee + Eligible Dependents**	**Adding dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)** **Dropping dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)**
☐ **Waive Dental**		

Vision Plan Options:

Vision Service Plan ☐ **VSP Signature Plan** ☐ **VSP Choice Plan**	**New Coverage Level:** (MEF, CAMP, ALP, AEA, AMSP, Unit 81/82, Unit 99) ☐ **Employee Only** ☐ **Employee + Spouse/DP** ☐ **Employee + Child(ren)** ☐ **Employee + Spouse/DP + Child(ren)** **New Coverage Level:** (ABMEI, IAFF, IBEW, OE3, and POA) ☐ **Employee Only** ☐ **Employee + 1 Dependent** ☐ **Employee + 2 or more**	**Adding dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)** **Dropping dependents:** ☐ **Spouse or Domestic Partner** ☐ **Child(ren)**
☐ **Waive Vision**		

Employee Assistance Program:

☐ **Managed Health Network (MHN)**	**New Coverage Level:** ☐ **Employee** ☐ **Employee + Eligible Dependents**

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Dependent Information:

For any new dependents who are to be **added to the coverage**, fill out all the information in the boxes below. You do not need to fill out the information for any dependents currently on your coverage that are remaining on your coverage.

For **dependents being dropped**, provide the dependent's name and last 4 digits of the Social Security Number.

Relation	Gender	Last Name	First Name	Birth Date	SSN	Mark with "+" if adding, "-" if dropping, "=" if no change: Med	Den	Vis	EAP
☐ Spouse ☐ Domestic Partner	☐ Male ☐ Female								
Date of Marriage/Domestic Partnership: _____					PCP # (for HMO only): #_____				
Child	☐ Male ☐ Female								
Choose one:	☐ Natural ☐ Step ☐ Guardianship ☐ Adopted ☐ DP's Child				PCP # (for HMO only): #_____				
Child	☐ Male ☐ Female								
Choose one:	☐ Natural ☐ Step ☐ Guardianship ☐ Adopted ☐ DP's Child				PCP # (for HMO only): #_____				

**For additional dependents, please attach a separate sheet of paper.*

REQUEST TO PROVIDE DEPENDENT COVERAGE UNDER EMPLOYEE BENEFIT PLANS

If you are an employee requesting a mid-year change, complete this section to verify dependency and eligibility for enrollment if you DO NOT have copies of birth certificates for your dependent children and/or a marriage certificate to for your spouse.

I request that the individuals listed above be covered under my City health plan, dental plan, and other employee benefit plans, as my eligible dependents under the terms of these plans. I certify that the individual(s) listed is/are my spouse and/or my unmarried child(ren), or the unmarried child(ren) of my spouse, and meet the dependent eligibility rules set forth by the City of San José.

My signature here means I understand that if I do not provide formal documentation within **60 days** of the qualifying event date, my enrolled dependents will be dropped from coverage retroactive to the date that I enrolled them, and I may be required to repay any claims or other costs, including premium costs, incurred by either the providers or the City on behalf of the individual(s) listed.

SIGNATURE: _____ **DATE:** _____

Anthem Arbitration Agreement

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By checking the checkbox for this section and clicking on the Submit button below, you agree this acknowledgement is valid and binding.

ANTHEM ENROLLEE SIGNATURE: _____ **DATE**: _____

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.

KAISER ENROLLEE SIGNATURE: _____ DATE: _____

Waiver of Healthcare Acknowledgement

Having met the eligibility requirements, you and your eligible dependents are being offered the opportunity to enroll in health coverage offered by the City of San José. You have the right to decline, or waive, coverage. The decision to waive coverage may have consequences for you. For example:

- The City offered health benefits is considered affordable and meets the minimum essential coverage under the Patient Protection and Affordable Care Act (ACA), so you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.
- If you waive this coverage and do not obtain coverage on your own, you will be subject to a penalty under the individual responsibility requirement of the ACA.
- If you waive coverage, you cannot enroll in the City's health plan until the next open enrollment, unless you experience a qualifying event. Any qualifying event request must be completed within 30 days of the qualifying event. If you miss this 30-day enrollment deadline, you must wait until open enrollment.
- If you waive coverage for yourself, you may not cover dependents under the City's health plan.

I acknowledge that the City of San José has offered me affordable minimum essential coverage, as defined under the ACA, for the 2020 plan year. I have read the above and I understand the consequences of my waiver of coverage.

EMPLOYEE SIGNATURE: _____DATE: _____

All Employees

I authorize my health plan carrier to release or obtain health information on myself and covered dependents to or from health care providers/agencies, for providing necessary health care services, utilization review, quality assurance, surveys, processing of claims, financial audit or purposes reasonably related to the performance of the agreement or policy.
I agree to be bound by the benefits, limitations, exclusions and other terms of the applicable group agreement and any amendments to the group agreement. I understand that only my legal dependents, as defined by the City of San José, may be enrolled in my medical, dental, and vision plans. I authorize the City of San José to take deductions from my paycheck to pay for my benefit costs. I understand that benefits coverage will continue to the last day of the month in which I separate from City service or lose benefits eligibility, and that I am responsible for paying my share of any premium for that month of coverage. I declare ***that all the information provided herein is true and correct.*** I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact that my coverage may be cancelled or, following notice, my employer's contract rescinded.

EMPLOYEE SIGNATURE: _____ DATE: _____

PRINT/TYPE NAME: _____ EmpID#_____