CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Name: _____ **ID#** _____

	NEW/PROMOTED EMPLOYEE BENEFITS ENROLLMENT ACKNOWLEDGEMENT	INITIAL
1.	I understand as a new or promoting employee, I have 30 days from my date of promotion or date of hire (Eligibility Date) to enroll in my benefit plans.	
2.	I understand the City's health benefit plans will be effective the first of the month following my enrollment date.	
3.	I understand I must provide documentation to HR for all dependents I wish to enroll on the City's benefit plans within 30 days of my Eligibility Date (e.g., birth certificate, marriage certificate, Affidavit of Domestic Partnership, etc.).	
4.	I understand if I do not complete the enrollment process within 30 days, I will be defaulted to the Anthem Blue Cross $1500 Deductible Select HMO single medical plan and the DeltaCare HMO single dental plan.	
5.	I understand my City's benefit insurance premiums are deducted from the 1st and 2nd paychecks of each month.	
6.	I understand if I have a Qualifying Life Event (birth of a child, marriage, loss of coverage, etc.), I have 30 days from the Qualifying Life Event to make limited changes to my benefit plans. Example: marriage on March 1st, March 1st will be counted as day 1. I understand that late enrollment will not be accepted.	
7.	I understand the Health and Dental In-Lieu Plan option is different than "waived". Should I choose to enroll in Health and Dental In-Lieu Plan, I will furnish proof of alternate group coverage within 30 days of the Eligibility Date and annually as requested. I understand that failure to provide this documentation will result in being dropped from the In-Lieu program.	
8.	I understand that outside of the initial 30-day window, I will not be allowed to change enrollment or add dependents without a Qualifying Life Event or until the City's next Open Enrollment period.	
9.	I understand HMO and PPO medical plans have been offered to me, and that I should review the HR intranet site for additional plan information. I understand if I live outside of a service area, my dependents and I will need to seek services at an in-network facility, except for emergency room visits.	
10.	I understand FSA (Flexible Spending Accounts) have been offered to me. I understand that these accounts are subject to IRS section 125 "Use it or Lose it" Rule. I also understand I must remain enrolled for the entire year and must re-enroll for every new plan year. I understand that previous participation/contributions in an FSA plan with a prior employer within the current year should be considered prior to enrolling due to contribution limits.	
11.	**I understand that the City of San José does not contribute to State Disability Insurance (SDI)**. I understand I have been offered to enroll in an optional Long Term Disability plan. I understand enrollment within the first 30 days will not be subject to Evidence of Insurability (EOI) however, any time after my first 30 days of eligibility will be subject to EOI and I may be denied.	
12.	I understand it is my responsibility to enter and update beneficiary information, emergency contact and change of address information for all benefit plans directly with the vendors and departments (life insurance, Deferred Compensation, Retirement Services) and eWay. I understand that I must keep these beneficiary names current and review them each year at open enrollment or during a Qualifying Life Event.	
	I have reviewed and understand all the information contained on this form. **Signature:** **Date:**	