CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Human Resources
2022 Enrollment Change Form

Print or type clearly. Completed, signed requests must be sent to: Human Resources (HR is currently working remotely.) – Email to: HRBenefits@sanjoseca.gov

Last Name	First Name	Employee ID

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:

- ☐ **$20 Copay Select HMO Plan***
- ☐ **$20 Copay Traditional HMO Plan***
- ☐ **$1,500 Deductible Select HMO Plan***

**Anthem PCP #:* _____

- ☐ **$100 Deductible Select PPO Plan**
- ☐ **$100 Deductible Classic PPO Plan**
- ☐ **$2,500 Deductible Classic PPO Plan w/HSA**

☐ **Health In-Lieu Plan** (Must sign the Cash In-Lieu Attestation on page 4)

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** (Must sign the Cash In-Lieu Attestation on page 4)

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:

☐ **Employee Assistance Program**	**Coverage Level:** ☐ **Employee + Eligible Dependents**

Human Resources
2022 Enrollment Change Form

Dependent Information:
For any dependents who are to be added to coverage, please fill out all information in the boxes below.

For dependents that are being removed from coverage, provide the dependents first and last name and date of birth.

Relation	Gender	Last Name	First Name	Birth Date	SSN	Mark with "+" if adding Mark with "-" if dropping Mark with "=" 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): #_____________________				
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): #_____________________				
Child	☐ Male ☐ Female								
Choose one:	☐ Natural ☐ Step ☐ Guardianship ☐ Adopted ☐ DP's Child				PCP # (for HMO only): #_____________________				

For additional dependents, please attach an additional copy of page 2

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.

_____ _____

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.*

Cash In-Lieu Attestation of Alternate Qualifying Group Health and/or Dental Insurance Coverage

I attest that my dependents and I are covered, or will be covered, by an alternate qualifying group health and/or dental plan that conforms to the Affordable Care Act's (ACA) minimum value standards for Calendar Year 2020. I attest that I will maintain coverage in this alternate qualifying group health and/or dental plan for Calendar Year 2020 and I agree to notify Human Resources, Benefits Division within 30 days of losing coverage under that medical and/or dental insurance plan. I understand that an individual health and/or dental insurance policy (for example Medicare, Covered California, or a policy purchased on a private or state exchange) is not qualifying group health and/or dental plan coverage for purposes of this Health and/or Dental Cash In-Lieu Benefit.
I hereby agree to all terms and conditions as contained in this Attestation and the Health and/or Dental In-Lieu Plan Document and that the terms and conditions are fully understood. I further certify that the information furnished is true and correct and understand that falsification of this Attestation may result in cancellation and repayment of Health and/or Dental In-Lieu payments.

EMPLOYEE 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#_____

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

Qualifying Event Date: _____ Coverage Effective Date: _____ Retroactive Enrollment? Y / N Premium Adjustment Required? Y / N

Comments: