LOS ANGELES COMMUNITY COLLEGE DISTRICT

2014 ENROLLMENT/CHANGE FORM

RETIREES/ SURVIVORS

1. Personal Information

Last | *First* | *MI* | *Social Security Number* | *Date of Birth*

Street Address (no P.O. Boxes) | *Home Phone* | *Cell Phone*

City | *State* | *Zip* | *Email Address*

Status:

☐ Married ☐ Divorced ☐ Widowed
☐ Domestic Partnered ☐ Single

2. Retiree Contact Person – Someone who will always be able to contact you

Last | *First* | *MI* | *Home Phone* | *Cell Phone*

Address | *relationship*

City | *State* | *Zip* | *Email Address*

3. Reason for Completing This Form

☐ New Enrollment
☐ Open Enrollment
☐ Name/Address Change
☐ Change in Dependent Coverage
☐ Refusing all health insurance – You will be subject to a waiting period or will be required to verify a recent life status change if you choose to add later.

Event – Life Status Change	Effective Date	Doc Enclosed
☐ Marriage/Domestic Partnership		Marriage License
☐ Dissolution of Marriage/Dom Part		Div/Diss Decree
☐ Death of Dependent		Certificate of Death
☐ Birth		Birth Certificate
☐ Adoption/Foster Child Placement		Court Papers
☐ Parent-Child Relation Established		Parent-Child Affidavit
☐ Spouse gained or lost coverage (change in employment status)		Ltr & copy of ins card (Marriage Lic)
☐ Child no longer eligible		
☐ Other		Call w/ questions

4. Dental Plan

☐ Delta Dental PPO
☐ MetLife Dental HMO (formerly Safeguard)

Coverage Type
☐ Retiree/Survivor only
☐ Retiree/Survivor + one
☐ Retiree/Survivor + Family

5. Vision Plan

☐ Vision Service Plan

Coverage Type
☐ Retiree/Survivor only
☐ Retiree/Survivor + one
☐ Retiree/Survivor + Family

Changes to medical plan must be handled directly with CalPERS.
You may contact them at (888) 428 – 2980.

NAME: _____ SSN: | | | | | | | | | |

6. Enrollment Information

If you are adding or removing dependents or changing address information at any time other than annual enrollment, you must submit this form within 60 days of a family status change (marriage, divorce, birth, etc.) or you will be required to wait 90 days after the day that it is submitted for changes to take effect.

Please complete the following section for each person you are enrolling, including yourself. If you are enrolling more than three children, please list their names and information on a separate page. Sign, date, and attach that page to this form.

Enrollee	Add	Delete	Name (Last on top line, First, MI)	Gender	Birth Date	Soc. Security #
Self	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Spouse/ Dom Partner	☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Child	☐ Dental ☐ Vision	☐ Dental ☐ Vision				
Child	☐ Dental ☐ Vision	☐ Dental ☐ Vision				

7. Dual Coverage

☐ My spouse/domestic partner is an LACCD employee/retiree. His/her employee number is: _____ .

☐ My spouse/domestic partner works for (or retired from) an agency that has group health insurance administered by CalPERS[1].

☐ My spouse/domestic partner does not have health benefits administered by CalPERS; neither as an active employee nor as a retired employee.

NOTE: If CalPERS rejects your enrollment through LACCD due to dual enrollment (CalPERS administered benefits sponsored by another agency) you will not be added to health benefits until the dual coverage issue is corrected.

[1] An employee may be enrolled as an enrolled CalPERS primary insurance carrier or as a dependent of another CalPERS enrollee or retiree, but not both. An individual may be included as a dependent under the enrollment of only one employee or retiree.

NAME: _____ SSN: | | | | | | | | | |

8. How to Submit this Enrollment/Change Form

In order to enroll or change your plan, you must:

1. Complete *and* Sign this form.
2. If you are adding dependents, attach PHOTOCOPIES of 1) the social security card for all dependents. We allow a 90 day grace period for the card and number of newborns, and 2) A birth certificate (children), marriage certificate or domestic partner registration (spouse/dom partner). See your union contract for clarification on an eligible domestic partner.
3. If you are deleting dependents, attach PHOTOCOPIES of dissolution of marriage or domestic partnership. If you have questions as to which documents are needed for verification, contact the Health Benefits Unit by telephone at (888) 428-2980 or via email at do-sap-benefits-health@email.laccd.edu.
4. Send this form and the attached PHOTOCOPIES of verification documents using ***one*** of the following methods:

US Mail	*Courier*	*Secure Fax*	*Email*
LACCD Health Benefits Unit 770 Wilshire Blvd., 6th Floor Los Angeles, CA 90017	**District Office** Health Benefits Unit 6th Floor	**Health Benefits Unit** (213) 891-2008	**Use address in #3**

_____ ***initial*** I understand that the elections I make on this form will remain as long as I am eligible or until I make another election during annual enrollment. I am enrolling for myself and those eligible dependents that I have listed in Part 6 of this form for coverage under the plan(s) I have selected.

_____ ***initial*** ***I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents within 60 days***. Further, if I fail to report status changes within 60 days, I understand that I could be liable for retroactive premium payments in excess of the amount of my plan if I had reported the change in time, and I further understand that I could be liable for medical expenses incurred by the ineligible party.

_____ ***initial*** I understand that missing documentation will result in a delay in processing that will leave me and/or my dependents without coverage until all information is submitted, and I further understand that my benefits become effective *after* I submit all documents to complete the enrollment process.

X _____ _____
Signature ***Date***

9. MetLife Dental Provisions

Each and every disagreement, dispute or controversy which remains unresolved concerning the construction, interpretation, performance or breach of this contract, or the provision of dental services under this contract after exhausting MetLife's complaint procedures, arising between the organization, a member or the heir-at-law or personal representative of such person, as the case may be, and MetLife, its employees, officers or directors, or participating dentist or their dental groups, partners, agents, or employees, may be voluntarily submitted to arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice; that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this contract but which gives rise to a claim after the termination of this contract. Arbitration shall be initiated by written notice to the President, MetLife Health Plans, Inc., P.O. Box 30900, Laguna Hills, California 92654-0900. The notice shall include a detailed description of the matter to be arbitrated.

X _____ _____
Signature ***Date***

FOR HEALTH INSURANCE SECTION USE

Event Date: _____
Date Processed: _____
Processed By: _____