Los Angeles Community College District

Active – Adjunct Employee or COBRA Participant

2013 Enrollment/Change Form

Personal Information

Last Name	*First Name*	*MI*	*Social Security Number*	*Date of Birth*
Street Address (no P.O. Boxes)			*Home Phone*	*Work Phone*
City	*State*	*Zip*	*Employee Number*	*Work Location*
			Email Address	

Status:

☐ Married ☐ Divorced ☐ Widowed ☐ Full-time Active ☐ Part-time Adjunct

☐ Domestic Partnered ☐ Single ☐ COBRA

I want to use my ☐ Home address ☐ Work address as my Benefit Service Address (the address for my plan[1].)

Reason for completing this form

☐ New Enrollment

☐ Open Enrollment – with prior approval from the Health Benefits Unit. Otherwise, use Employee Self Serve (portal)

☐ 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(s) Enclosed**
☐ New hire/rehire/return from leave		
☐ Marriage/domestic partnership		Marriage license
☐ Dissolution of marriage/domestic partnership		Divorce/dissolution decree
☐ Death of dependent		Certificate of death
☐ Birth		Birth certificate
☐ Adoption/foster child placement		Court papers
☐ Parent-child relationship established		Parent-child affidavit
☐ Child no longer eligible		
☐ Loss of hours/employment		Letter & copy of insurance card
☐ Spouse gained or lost coverage		Letter & copy of insurance card
☐ Other		Call w/questions

Medical Plan

PPO (Anthem Blue Cross)

☐ **PERSCare[2] (employee pays part of the premium)**

☐ PERS Choice[3]

☐ PERS Select[3]

HMO

☐ Blue Shield Access+[4]

☐ Blue Shield NetValue[4]

☐ Kaiser Permanente

Coverage Type

☐ Employee only

☐ Employee + one

☐ Employee + family

Dental Plan

☐ Delta Dental PPO

☐ MetLife Dental HMO (formerly SafeGuard)

Coverage Type

☐ Employee only

☐ Employee + one

☐ Employee + family

Vision Plan

☐ Vision Service Plan

Coverage Type

☐ Employee only

☐ Employee + one

☐ Employee + family

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[1] If you choose an HMO, your Benefit Service Address must be within 30 miles of the physician/hospital that you choose.

[2] PERSCare is a 90/10 coverage plan used in coordination with Medicare. ***A non-Medicare employee who chooses this plan will be responsible for premium payment over and above the PERS Choice amount.***

[3] PERS Choice and Select are similar 80/20 coverage plans, but Select has a smaller physician network.

[4] Blue Shield Access+ and NetValue are similar plans, but NetValue has a smaller network of physicians.

Name: ______________________ SSN | | | | | | | | | |

Enrollment Information

If you are adding or removing dependents or changing address information at any time other than annual open 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	Social Security #
Self	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Spouse/Domestic Partner	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				

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. (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.

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

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.

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, Incl, P.O. Box 30900, Laguna Hills, California 92654-0900. The notice shall include a detailed description of the matter to be arbitrated.

______________________ ______________________

Signature Date

Name: ______________________ SSN | | | | | | | | | |

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) a social security card for each dependent and 2) birth certificates (for children), marriage license or domestic partner registration (for spouse or domestic partner). We allow a 90-day grace period for photocopies of the social security cards/social security numbers for newborns. Please see your union contract for clarification regarding eligible domestic partners.
3. If you are deleting dependents, attach a photocopy of your 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 the required documentation using **one** of the following methods:

US Mail: LACCD Health Benefits Unit, 770 Wilshire Blvd., 6th Floor, Los Angeles, CA 90017

Courier: District Office, Health Benefits Unit, 6th Floor

Secure Fax: Health Benefits Unit (213) 891-2008

Email: Do-sap-benefits-health@email.laccd.edu

_______ Initial — I understand that the elections I make on this form will remain in effect as long as I am eligible or until I make another election during annual open enrollment. I am enrolling for myself and those eligible dependents that I have listed in the Enrollment Information section 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 that my plan would have been had I reported the change on 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 unit all information is submitted. I further understand that my benefits become effective the first day of the following month after I submit all documents to complete the enrollment process.

_______ Initial — ***I understand that if I enroll in PERSCare, I will pay part of the premium. The difference between PERSCare and PERS Choice will be deducted from my paycheck.***

For new employees:

_______ Initial — ***I understand that I must submit my application for enrollment within 60 days of being hired and that my benefits will begin on the first of the month following the date that the Health Benefits Unit receives my application.***

______________________________ Signature

______________________________ Date

For Health Insurance Section Use Only

☐ Medical
☐ Dental
☐ Vision

☐ Employee Assistance Program
☐ Life Insurance
☐ HRA Card

If benefits begin on or before 3/1. Adjuncts are not eligible for the HRA or life insurance.

Event Date: ______________

Date Processed: ______________

Processed by: ______________