



LOS ANGELES COMMUNITY COLLEGE DISTRICT

ACTIVE & ADJUNCT EMPLOYEES

2014 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
 I want to use my Home Work address as my Benefit Service Address (the address for my plan¹.)

Reason for completing this form

	Event – Life Status Change	Effective Date	Doc(s) Enclosed
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> New hire/rehire/return from leave	_____	_____
<input type="checkbox"/> Open Enrollment – with prior approval from the Health Benefits Unit. Otherwise, use Employee Self Serve (portal)	<input type="checkbox"/> Marriage/domestic partnership	_____	Marriage license
	<input type="checkbox"/> Dissolution of marriage/domestic partnership	_____	Divorce/dissolution decree
<input type="checkbox"/> Name/address change	<input type="checkbox"/> Death of dependent	_____	Certificate of death
<input type="checkbox"/> Change in dependent coverage	<input type="checkbox"/> Birth	_____	Birth certificate
	<input type="checkbox"/> Adoption/foster child placement	_____	Court papers
	<input type="checkbox"/> Parent-child relationship established	_____	Parent-child affidavit
<input type="checkbox"/> 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.	<input type="checkbox"/> Child no longer eligible	_____	Ltr & copy of ins card
	<input type="checkbox"/> Loss of hours/employment	_____	Ltr & copy of ins card
	<input type="checkbox"/> Spouse gained or lost coverage	_____	Ltr & copy of ins card
	<input type="checkbox"/> Other	_____	Call w/questions

Medical Plan

PPO (Anthem Blue Cross)		HMO	
<input type="checkbox"/> PERSCare 2 (employee pays part of the premium)	<input type="checkbox"/> Blue Shield Access+ ⁴	<input type="checkbox"/> Anthem Select	
<input type="checkbox"/> PERS Choice ³	<input type="checkbox"/> Blue Shield NetValue ⁴	<input type="checkbox"/> Anthem Traditional	
<input type="checkbox"/> PERS Select ³	<input type="checkbox"/> Kaiser Permanente	<input type="checkbox"/> United Healthcare	
	<input type="checkbox"/> Health Net Salud y Más	<input type="checkbox"/> Health Net SmartCare	
	<input type="checkbox"/> Sharp		
Coverage Type:	<input type="checkbox"/> Employee only	<input type="checkbox"/> Employee + one	<input type="checkbox"/> Employee + family

Dental Plan

<input type="checkbox"/> Delta Dental PPO	<input type="checkbox"/> MetLife Dental HMO (formerly SafeGuard)	Coverage Type
		<input type="checkbox"/> Employee only
		<input type="checkbox"/> Employee + one
		<input type="checkbox"/> Employee + family

Vision Plan

<input type="checkbox"/> Vision Service Plan	Coverage Type
	<input type="checkbox"/> Employee only
	<input type="checkbox"/> Employee + one
	<input type="checkbox"/> Employee + family

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	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Spouse/Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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) the social security card for all dependents and 2) a birth certificate (for children), marriage license or domestic partner registration (for spouse or domestic partner). We allow a 90-day grace period for the photocopy of the social security card/social security number for newborns. Please see your union contract for clarification regarding an eligible domestic partner.
3. If you are deleting dependents, attach photocopies of you 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 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

_____ 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.

_____ ***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 on time, and I further understand that I could be liable for medical expenses incurred by the ineligible party.

_____ 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.

_____ ***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:

_____ ***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 after 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: _____