

LOS ANGELES COMMUNITY COLLEGE DISTRICT



ACTIVE EMPLOYEE/COBRA

2009 ENROLLMENT/CHANGE FORM

1. Personal Information

Name (Last, First, MI)	Social Security Number	Work Location (Active Employees Only) Circle one: C E H M P S T V W DISTRICT	
Street Address	Birth Date	Home Phone	Work Phone
City/State/Zip	Check one: <input type="checkbox"/> Active employee <input type="checkbox"/> COBRA participant	Check one: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Employee Number

2. Reason for Completing This Form

<input type="checkbox"/> Annual enrollment <input type="checkbox"/> New enrollment <input type="checkbox"/> Refusing all health insurance <input type="checkbox"/> Name/address change <input type="checkbox"/> Change in dependent coverage <p style="text-align: center;">↓</p> <p>Indicate a reason in the next column if you are adding or removing a dependent from your coverage.</p>	Change in Status <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Legal Separation <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Child past eligible age <input type="checkbox"/> Death of dependent <input type="checkbox"/> Spouse gained or lost coverage <input type="checkbox"/> Other	Date of Change of Status _____ _____ _____ _____ _____ _____ _____ _____
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3. Medical Coverage

Indicate your choice below:	Indicate coverage level:
<input type="checkbox"/> Blue Shield PPO Plan <input type="checkbox"/> Blue Shield HMO Plan – Complete Part 6-B on back side <input type="checkbox"/> Kaiser Permanente HMO	<input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family

4. Dental Coverage

Indicate your choice below:	Indicate coverage level:
<input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> SafeGuard Dental HMO – Complete Part 6-B on back side	<input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family

5. Vision Coverage

Indicate your choice below:	Indicate coverage level:
<input type="checkbox"/> Vision Service Plan	<input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family

6. Enrollment Information

All COBRA participants must respond by **November 26, 2008** in order to continue LACCD-sponsored benefits. If you are adding or removing dependents or changing address information during annual enrollment, you are required to complete this form. Otherwise, you must enroll new dependents within 31 days of a family status change (marriage, divorce, birth, etc.).

PART 6-A – Enrollee Information

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.

	Add	Delete	Name (Last, First, MI)	Sex	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				
<input type="checkbox"/> Spouse <input type="checkbox"/> 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				

PART 6-B – Primary Care Provider Information

If you selected the Blue Shield HMO or the SafeGuard HMO, you must fill out this section. Enter the personal physician or primary care dentist information for each enrollee. The provider ID number and name can be found in the provider directory at www.blueshieldca.com or www.safeguard.net.

	Enter provider name and ID # of Blue Shield physician	Enter provider name and ID # of SafeGuard dentist
Self		
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		
Child		
Child		
Child		

7. Medicare Details

<input type="checkbox"/> Employee/COBRA participant has Medicare coverage Part A <i>Effective date:</i> _____ Part B <i>Effective date:</i> _____ Part D <i>Effective date:</i> _____	<input type="checkbox"/> Spouse/domestic partner has Medicare coverage Part A <i>Effective date:</i> _____ Part B <i>Effective date:</i> _____ Part D <i>Effective date:</i> _____	<input type="checkbox"/> Child has Medicare coverage Part A <i>Effective date:</i> _____ Part B <i>Effective date:</i> _____ Part D <i>Effective date:</i> _____
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8. Other Medical Coverage (Besides Medicare)

<input type="checkbox"/> Employee/COBRA participant has other medical coverage	<input type="checkbox"/> Spouse/domestic partner has other medical coverage	<input type="checkbox"/> Child has other medical coverage
Name of covered individual _____ Employer (if applicable) _____ Address _____	Social Security number _____ Insurance company _____ Phone number _____ Policy number _____	
Name of covered individual _____ Employer (if applicable) _____ Address _____	Social Security number _____ Insurance company _____ Phone number _____ Policy number _____	

9. Is Your Spouse or Domestic Partner an LACCD Employee?

My spouse/domestic partner is an LACCD employee. His/her employee number is: _____
An employee may be included as enrolled employee OR as a dependent of another employee or retiree, but not both. An individual may be included as a dependent under the enrollment of only one employee or retiree.

10. How to Submit This Enrollment/Change Form

In order to enroll in or change your medical, dental, or vision coverage, you must:

1. Complete this form.
2. Sign the next page of the form.
3. If you are adding dependents, attach PHOTOCOPIES of the required dependent eligibility verification documents to this form, such as birth certificate, proof of full-time student status, marriage certificate, domestic partner registration, and/or court order. *If you have questions as to which documents are needed to verify eligibility, contact the LACCD Health Benefits Call Center at (888) 428-2980.*
4. Send this form and the attached PHOTOCOPIES of verification documents in the enclosed envelope to:
LACCD Health Benefits Call Center
 770 Wilshire Blvd., 6th Floor
 Los Angeles CA 90017
 (888) 428-2980

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 enrollment. I am enrolling for myself and those eligible dependents I have listed in Part 6-A 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 31 days. I also understand that the benefits and services of the plan(s) I elected are coordinated with those provided by any other group medical or dental plan for which I am eligible. By signing this form below, I certify that I understand the benefit options available to me and accept full responsibility for my elections. I also declare under penalty of perjury under the laws of the State of California that the information and documentation I have provided are true and accurate to the best of my knowledge. I attest by signing below that I have reviewed the information provided on this form and, to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

X _____
 Your Signature Date

DO NOT COMPLETE THE SHADED AREA BELOW

Medical Group	Dental Group No.	Effective Date	Hire Date	Dental Maximum	Authorized By

To complete your enrollment, you must read the arbitration information on the following page and sign at the bottom.

Safeguard 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 SafeGuard'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 SafeGuard, 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, SafeGuard 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.

Kaiser Permanente Provisions

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.

Please Sign Below

X _____

Your Signature

_____ **Date**