



# LOS ANGELES COMMUNITY COLLEGE DISTRICT

ACTIVE or ADJUNCT EMPLOYEE or COBRA Participant

## 2010 ENROLLMENT/CHANGE FORM

### 1. Personal Information

|                                       |  |  |              |  |  |                   |  |  |                               |  |  |                      |  |  |
|---------------------------------------|--|--|--------------|--|--|-------------------|--|--|-------------------------------|--|--|----------------------|--|--|
| <i>Last</i>                           |  |  | <i>First</i> |  |  | <i>MI</i>         |  |  | <i>Social Security Number</i> |  |  | <i>Date of Birth</i> |  |  |
| <i>Street Address (no P.O. Boxes)</i> |  |  |              |  |  | <i>Home Phone</i> |  |  | <i>Work Phone</i>             |  |  |                      |  |  |
| <i>City</i>                           |  |  | <i>State</i> |  |  | <i>Zip</i>        |  |  | <i>Employee Number</i>        |  |  | <i>Work Location</i> |  |  |

**Status:**

Married       Divorced       Widowed  
 Domestic Partnered       Single

Active       COBRA       Part-time

I want to use my  Home/  Work address as my benefits services address—the address for my plan<sup>1</sup>.  
*Choose one*

### 2. Reason for Completing This Form

|  | Event  | Effective Date | Doc Enclosed             |
|--|--|----------------|--------------------------|
| <input type="checkbox"/> New Enrollment                | <input type="checkbox"/> New Hire/Rehire/Return from Leave                               | _____          | <input type="checkbox"/> |
| <input type="checkbox"/> Open Enrollment               | <input type="checkbox"/> Marriage/Domestic Partnership                                   | _____          | <input type="checkbox"/> |
| <input type="checkbox"/> Name/Address Change           | <input type="checkbox"/> Dissolution of Marriage/Dom Part                                | _____          | <input type="checkbox"/> |
| <input type="checkbox"/> Change in Dependent Coverage  | <input type="checkbox"/> Death of Dependent  | _____          | <input type="checkbox"/> |
| <input type="checkbox"/> Refusing all health insurance | <input type="checkbox"/> Birth   | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Adoption  | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Economically Dependent Child                                    | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Child no longer eligible  | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Loss of hours/employment (LACCD)                                | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Spouse gained or lost coverage<br>(change in employment status) | _____          | <input type="checkbox"/> |
|  | <input type="checkbox"/> Other   | _____          | <input type="checkbox"/> |

### 3. Medical Plan<sup>2</sup>

| <u>PPO</u> (Anthem Blue Cross)       | <u>HMO</u>                                    | Coverage Type                              |
|--------------------------------------|---|--|
| <input type="checkbox"/> PERS Care   | <input type="checkbox"/> Blue Shield Access + | <input type="checkbox"/> Employee only     |
| <input type="checkbox"/> PERS Choice | <input type="checkbox"/> Blue Shield NetValue | <input type="checkbox"/> Employee + one    |
| <input type="checkbox"/> PERS Select | <input type="checkbox"/> Kaiser Permanente    | <input type="checkbox"/> Employee + Family |

### 4. Dental Plan

|  |  |
|--|--|
| <input type="checkbox"/> Delta Dental PPO                        | Coverage Type                              |
| <input type="checkbox"/> MetLife Dental HMO (formerly Safeguard) | <input type="checkbox"/> Employee only     |
|  | <input type="checkbox"/> Employee + one    |
|  | <input type="checkbox"/> Employee + Family |

### 5. 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 |

<sup>1</sup> If you choose an HMO, your benefits services address must be within 30 miles from the physician/hospital that you choose.

<sup>2</sup> PERS Care is a 90/10 coverage plan used in co-ordination with Medicare. A non-Medicare employee can choose this plan but he/she will be responsible for premium payment over and above PERS Choice amount. PERS Choice and Select are similar 80/20 coverage plans. The difference is that Select has a smaller physician network. Blue Shield Access + and NetValue are similar HMO plans, but NetValue has a smaller network of physicians.

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                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision |                                    |        |            |                 |
| Spouse/<br>Dom Partner | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision |                                    |        |            |                 |
| Child                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision |                                    |        |            |                 |
| Child                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision |                                    |        |            |                 |
| Child                  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision | <input type="checkbox"/> Medical<br><input type="checkbox"/> Dental<br><input type="checkbox"/> Vision |                                    |        |            |                 |

**7. HMO Information**

If you selected the Blue Shield or the MetLife HMO, you must fill in this section. Enter the primary care physician or primary care dentist's information for each enrollee. The physician IPA number and name can be found in the provider directory at [www.blueshieldca.com/calpers](http://www.blueshieldca.com/calpers). The dentist name and facility number can be found at [www.metdental.com](http://www.metdental.com). Contact the dental office for the facility number. When you receive your medical/dental card please verify that the physician/dentist that you selected is the one to which you've been assigned. If not, contact Blue Shield/MetLife immediately to be assigned appropriately.

| Enrollee             | Blue Shield HMO Provider Name and IPA | MetLife HMO Provider Name and Facility # |
|----------------------|---------------------------------------|--|
| Self                 |                                       |  |
| Spouse/Dom Partner   |                                       |  |
| Child/Children Name: |                                       |  |
| 1.                   |                                       |  |
| 2.                   |                                       |  |
| 3.                   |                                       |  |

**8. Dual Coverage**

- My spouse/domestic partner is an LACCD employee/retiree. His/her employee number is: \_\_\_\_\_.
- My spouse/domestic partner works for an agency that has group health insurance administered by CalPERS<sup>3</sup>.
  - I am enrolled on my spouse/domestic partner's CalPERS administered health insurance plan.
  - I am not enrolled on my spouse/domestic partner's CalPERS administered health insurance plan.

<sup>3</sup> 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: | | | | | | | | | |

**9. 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 the required dependent eligibility verification documents to this form, such as birth certificate, marriage certificate, and/or domestic partner registration.
- 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 Call Center at (888) 428-2980.*
- 4. Send this form and the attached PHOTOCOPIES of verification documents to:

**LACCD Health Benefits Call Center**  
 770 Wilshire Blvd., 6th Floor  
 Los Angeles, CA 90017  
 (888) 428-2980

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

**10. 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**

**SAP:**

- Medical
- Dental
- Vision
- Emp Assistance Program
- Life Insurance
- HRA Card\* (if benefits begin on or before 3/1)

**Carriers:**

- Medical
- Dental
- Vision
- Emp Assistance Program
- Life Insurance
- HRA Card\* (if benefits begin on or before 3/1)

Event Date: \_\_\_\_\_  
 Date Processed: \_\_\_\_\_  
 Processed By: \_\_\_\_\_

\* Adjuncts are not eligible for the HRA