Supporting Documentation – Dependent Verification

CalPERS is required under the Affordable Care Act (ACA) to report to the IRS who is enrolled in their health plans. As such, CalPERS requires the employer to obtain and retain social security numbers for covered members and their dependents. CalPERS will use such information for ACA tax compliance purposes.

The following list will help you identify the required documents for each eligible dependent. **Please submit a copy of the social security card for yourself and all dependents listed on your plan.** If you are adding a newborn, you will have 90 days to submit a copy of the social security card. If you are adding an adult who does not have a social security card, you must submit an HBD -12 to be faxed to CalPERS for a CalPERS enrollment. In addition, submit documents as listed below for dependent type:

Health Benefits

- ☐ **Current spouse -** A copy of your marriage certificate **AND one of the following:**
  - ☐ A copy of the front page of your most recent federal or state tax return confirming this dependent is your spouse **OR**
  - ☐ A document dated within the last 60 days showing current relationship status, such as a recurring household bill or statement of account if you are recently married (a tax year has not passed). *The document must list your name, your spouse's name, the date and your mailing address.*

- ☐ **Current registered domestic partner[1] -** A copy of your Declaration of Domestic Partnership **AND one of the following:**
  - ☐ A copy of the front page of your must recent federal or state tax return **OR**
  - ☐ A document dated within the last 60 days showing current relationship status, such as a recurring household bill or statement of account if you are recently married (a tax year has not passed). *The document must list your name, your partner's name, the date and your mailing address.*

- ☐ **Natural, adopted, step, or domestic partner's children up to age 26**
  - ☐ A copy of the child's birth certificate (or hospital birth record) or adoption certificate naming you or your spouse as the child's parent **OR**
  - ☐ A copy of the court order naming you or your spouse as the child's legal guardian.

Note: For a **stepchild**, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

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[1] Please see Union Contract for acceptable Domestic Partnership relationship. Domestic Partnership is defined as partners of the same-sex *or* partners in an inter-gender relationship if at least one partner is over 62.

- ☐ **Parent-Child Relation[2] for children up to age 26, for whom the employee assumes a primary parental role who is not his/her adopted, stop, or recognized natural born child** – a copy of the child's birth certificate and the parent child affidavit, and one of the following:
  - ☐ Newborn – Nothing more required.
  - ☐ Legal Guardian – A copy of the court order naming you or your spouse/domestic partner as the child's legal guardian. If a tax year has passed since the court order you most *also* submit a copy of your most recent tax return.
  - ☐ College Student – A copy of your tax return **OR**
    Evidence of full-time student status at an accredited educational institution ***and*** evidence that the child is dependent upon you for more than 50% of the student's support.

Note: Once the child is added to your benefits plan, you will be requested to submit a copy of your tax returns in subsequent years to maintain the child's eligibility. College Students are not mandated to be on your tax returns, but must maintain financial dependence and student eligibility.

Life Insurance

- ☐ Beneficiary Designation – Mandatory submission.
- ☐ Application for Life Insurance – Submit if purchasing additional life insurance.
- ☐ Evidence of Insurability - Submit if purchasing above 120K for employee and/or 50K for Spouse or Domestic Partner.

Waiver of Coverage

- ☐ Waiver of Benefits – Submit if waiving ***one or all*** benefits.

If you have questions, or to get an HBD-12 or a Parent Child Affidavit, please contact the Health Benefits Unit at (888) 4298 – 2980.

Health Benefits Unit

______________________	______________________
Supervisor	***Date***
______________________	______________________
Assigned Staff Member	***Date***

[2] A parent-child relationship is defined in the Public Employees' Medical and Hospital Care Act (PEMHCA) at § 599.500, subsection (o) as "intentional assumption of parental status, or assumption of parental duties by the employee or annuitant, as certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter up to the age of 26, unless the child is disabled as described in section 599.500, subdivision (p)." (Note: PCRs do not include foster children.)

LOS ANGELES COMMUNITY COLLEGE DISTRICT

ACTIVE & ADJUNCT EMPLOYEES

ENROLLMENT/CHANGE FORM

1. Personal Information

Last *First* *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
☐ Domestic Partnered ☐ Single

☐ Full-time Active ☐ Part-time Adjunct

I want to use my ☐ Home/ ☐ Work address as my benefits services address—the address for my plan[1].
Choose one

2. Reason for Completing This Form -

☐ New Enrollment

☐ Open Enrollment - with prior approval from the health benefits unit. Otherwise, use employee self serve (The 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	Event Date
☐ New Hire/Rehire/Return from Leave	________
☐ Marriage/Domestic Partnership	________
☐ Dissolution of Marriage/Dom Partner	________
☐ Death of Dependent	________
☐ Birth	________
☐ Adoption/Foster Child Placement	________
☐ Parent-Child Relation Established	________
☐ Child no longer eligible	________
☐ Loss of hours/employment	________
☐ Spouse gained or lost coverage (change in employment status)	________
☐ Other	________

3. Medical Plan

PPO (Anthem Blue Cross)	***HMO***	***HMO, part 2***	Coverage Type
☐ PERS Care[2]	☐ Anthem Select	☐ Health Net Smart Care	☐ Employee only
☐ PERS Choice[3]	☐ Anthem Traditional	☐ Health Net Salud y Mas	☐ Employee + one
☐ PERS Select[3]	☐ Blue Shield Access +	☐ Kaiser Permanente	☐ Employee + Family
		☐ Sharp[4]	
		☐ United Healthcare	

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

[2] PERS Care is a 90/10 coverage plan used in co-ordination with Medicare. ***The employee is responsible for premium payment over and above PERS Choice amount.***

[3] PERS Choice and Select are similar 80/20 coverage plans. The difference is that Select has a smaller physician network.

[4] Not available in Los Angeles County; available only in Southern California Region (San Diego).

NAME: ______________________________ SSN: | | | | | | | | |

4. Dental Plan

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

Coverage Type
☐ Employee only
☐ Employee + one
☐ Employee + Family

5. Vision Plan

☐ Vision Service Plan

Coverage Type
☐ Employee only
☐ Employee + one
☐ Employee + Family

6. Enrollment Information

If you are adding or removing dependents you must submit this form within 60 days of a family status change (new hire, marriage, divorce, birth, etc.) or you may be subject to 90 day penalty period with changes taking effect the first day of the month following the 90 day period.

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	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Spouse/ Dom 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				

7. Dual Coverage

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

☐ I understand that I and/or my dependents can only have one health plan administers by CalPERS. Further if I and/or my dependents am/are determined to be on another CalPERS plan, I/we can not enroll into LACCD's health benefits plan until I/we dis-enroll from the other CalPERS plan. [5]

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.

[5] 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. Flexible Spending Account

LACCD partners with Automatic Data Processing (ADP) to provide pre-tax Flexible Spending Account Services for our employees. Funds are deducted from January – December of the Calendar year with no deductions taken during the summer. ***Plan your deduction expenses accordingly*** because you will only be allowed to roll over up to 500.00 of unused funds at the end of the calendar year. Please visit ADP's website (www.spendingaccounts.info) to find out more about the plan, administration of the plan, and about eligible expenses.

NOTE: There is a calendar year maximum amount that can be contributed to each plan. The maximum dependent care contribution is 5,000.00 and the maximum Health Care contribution is 2,500.00.

_________ I would like to set aside _________________ this calendar year for Dependent Care expenses.
initial

_________ I would like to set aside _____________________ this calendar year for Health Care expenses.
initial

9. Life Insurance - Part time Faculty NOT ELIGIBLE

You are entitled to a 50,000.00 Life and Accident & Death policy with premiums paid by LACCD. In addition, you are entitled to purchase additional insurance for yourself and any dependents that you have. Please review the life insurance forms and make the appropriate selections for your needs. Even if you choose not to purchase additional coverage, you must submit a beneficiary designation for the Basic Coverage that LACCD provides.

_________ Life Insurance forms and/or Beneficiary Designation attached.
initial

- Beneficiary – The person(s) who inherits the claim should it be activated.
- Contingent beneficiary – The person(s) who inherits the claim as a secondary person if the beneficiary can not be located.
- If you choose life insurance for your spouse, you much purchase at least twice that amount for yourself.
- Life insurance is measured by units: 10,000.00 is 10 units, 5,000.00 is 5 units, etc. If you purchase voluntary life insurance, you find the cost according to your age and multiply by the number of units that you want to purchase.
- Life insurance for your spouse/dom partner is based on your age, not your spouse/dom partner's age.
- As a new employee, you may select insurance up to 120,000.00 for yourself and 50,000.00 for your spouse without submitting a Statement of Health (SOH). If you choose insurance ***above*** 120,000.00 (or 50,000.00 spouse/dom partner), you must submit a SOH. After status of new employee (60 days or more), you may only increase/decrease during open enrollment. At which time, you must submit a statement of health.

_________ I decline life insurance. I understand that I am not responsible for the premium for LACCD's Basic Life insurance policy, and am choosing to decline this benefit with full understanding of this fact.
initial

10. How to Submit this Enrollment/Change Form (Part 1)

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

1. Complete *and* Sign this form.
2. If you are submitting this form for any event other than Return from Leave you must provide supporting documents. Acceptable documents must prove the event that you are claiming. This can include a marriage license or State of California Domestic Partner Registration[6], court papers (divorce/dissolution decree, adoption or child care papers), certificate of death, birth certificate, or COBRA Letter from previous employer showing that job status change caused loss of insurance. In addition to those documents, **we require a copy of the social security card for all participants**.

[6] Please see your union contract for definition of acceptable Domestic Partner.

NAME: ________________________ SSN: | | | | | | | | | |

10. How to Submit this Enrollment/Change Form (Part 2)

3. 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 healthbenefits@email.laccd.edu
4. Send this form and the attached PHOTOCOPIES of supporting documents using ***one*** of the following methods:

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

Secure Fax
Health Benefits Unit
(213) 891-2008

Courier
District Office
Health Benefits Unit
6th Floor

Email
healthbenefits@email.laccd.edu

______ *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 the first day of the 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

______ *initial* ***For New Employees: I understand that I must submit my application for enrollment and insurance papers within 60 calendar days of being hired and that my benefits will begin on the first of the month after the Health Benefits Unit receives my application. I further understand that if I submit my documents after the first 60 calendar days then I will be subject to a 90 day waiting period before my benefits become effective, with benefits becoming effective the first day of the month following the waiting period.***

X ________________________ ________________
Signature ***Date***

FOR HEALTH INSURANCE SECTION USE

☐ Medical
☐ Dental
☐ Vision
☐ Life Insurance

☐ Emp 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: ____________