Human Resources / Employee Benefits
15600 Concord Circle, Morgan Hill, CA 95037
Office: (408) 201-6019 Fax: (408) 201-6026

Open Enrollment Benefit & Change Form

Effective January 1, 2019, I choose to enroll in the following health benefits:

Employee Information			
First Name:	Middle Initial:	Last Name:	
Work Location:		Classification:	

MEDICAL

Employee Group	Plan		Employee Only	2-Party	Family
	☐ WAIVE				
Available to all employees Managed by CalPERS Health Program	HMO	Anthem Select	☐ $831.44	☐ $1662.88	☐ $2161.74
		Anthem Traditional	☐ $1111.13	☐ $2222.26	☐ $2888.94
		Health Net Smart Care	☐ $901.55	☐ $1803.10	☐ $2344.03
		Kaiser Permanente	☐ $768.25	☐ $1536.50	☐ $1997.45
	PPO	PERS Choice	☐ $866.27	☐ $1732.54	☐ $2252.30
		PERS Select	☐ $543.19	☐ $1086.38	☐ $1412.29
		PERS Care	☐ $1131.68	☐ $2263.36	☐ $2942.37

DENTAL

Employee Group	Plan	Level	Employee Only	2-Party	Family
	☐ WAIVE				
Available to all employees	Delta Premier PPO	Low	☐ $50.39	☐ $100.78	☐ $170.37
		High	☐ $58.49	☐ $116.96	☐ $197.76
		Premium	☐ $64.72	☐ $129.43	☐ $218.81
	DeltaCare USA HMO		☐ $25.34	☐ $41.87	☐ $61.65

VISION

Employee Group	Plan	Level	Employee Only	2-Party	Family
	☐ WAIVE				
Available to all employees	Vision Service Plan (VSP)	Low	☐ $5.19	☐ $11.90	☐ $21.35
		Medium	☐ $6.19	☐ $14.19	☐ $25.43
		High	☐ $8.56	☐ $19.60	☐ $35.16

Turn over to complete side two-

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Complete Name (First Last)	Type	Date of Birth	M or F	Vision				Dental				Medical			
				Change	Add	Delete	Keep	Change	Add	Delete	Keep	Change	Add	Delete	Keep
	Employee			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Spouse			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Child			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Child			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Child			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Child			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

I hereby request health benefits as indicated on this form. I confirm that my information is accurate and complete. If I choose benefits that cost more than what my employer contributes, I agree to contribute the balance through payroll deductions which will reduce my net pay. I understand that I am not permitted to choose benefits that have out-of-pocket costs exceeding my net pay. I agree to the release of health information about me and my dependents for the purposes of managing and administering my benefits. I understand that my deductions may change periodically for benefit reconciliation. Even if I waive all or some of the health benefits, I understand that I may be enrolled in benefits that do not result in out-of-pocket costs to me. If I waive enrollment in the District's medical plan, I will provide proof of my other coverage each year during Open Enrollment.

I understand that the District highly recommends that all employees be enrolled in vision, dental, and medical plans and that all employees have a disability policy, especially since California State Disability Insurance (SDI) is not available to all employees. It is my responsibility to monitor my vacation and sick leave balances. I will read my union contract for a thorough understanding of allowed leaves of absences and how my pay and benefits might be affected.

If I have enrolled my dependents, I agree to complete the Dependent Verification form and submit proof of eligibility during open enrollment. If all required documentation is not submitted during open enrollment, I under I have to wait until the next Open Enrollment period to add my dependents unless there is a family status change or qualifying event. I understand that some benefits are only offered at the time of hire and may not be considered as a part of an Open Enrollment period. It is my sole responsibility to report my medical coverage accurately when I file my income tax returns and report information regarding the Affordable Care Act. I have read all benefit forms completely and have had all my questions answered. I agree to follow all District and plan rules for the plans which I have requested enrollment.

Employee's Signature _____ Date _____