Date: _____

Contra Costa Community College District

Universal Benefit Enrollment/Change Form (Active Employees)

This form does not replace the information provided by the carriers.
Read the carrier information carefully before selecting the options below. Adjunct Instructors use different form.

I. Employee Information

Employee Name (Last, First, Middle)		Employee ID:		
		☐ New Hire ☐ Existing Hire		
Address (street, apartment number, city, state, zip)		*Group*	*Status*	*Location*
		☐Faculty ☐Classified ☐Mgmt./Conf.	☐Full-Time ☐MonthlyClassified Under40Hrs: __	☐CCC ☐Dist. ☐DVC ☐LMC ☐SRC ☐BRW
Home Phone	*Cell Phone*	*Hire Date*	*SS#*	
Gender: ☐ M ☐ F	*Date of Birth*	*Title*		
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner		*Email Address*		

II. Enrollment:

☐ Open Enrollment ☐ Monthly Election ☐ New Hire

☐ **Other Qualifying Event:** *Fill in description and date-->*

Description	*Date*

Submit this form within 30 days of qualifying event (e.g., birth of child, marriage, and divorce). Changes are effective the first day of the month following the date of the event (Pension Dynamics has additional qualification dates). ***ALL FIELDS MUST BE FILLED!***

	No Coverage*	Enroll	Change in Coverage	No Change	Plan	Teir: Single	2-Party	Family	N/A
Medical	☐	☐	☐	☐	Anthem/Blue Cross EPO	☐	☐	☐	☐
		☐	☐	☐	Kaiser HMO	☐	☐	☐	☐
		☐		☐	Cash Election**				
Dental	☐	☐	☐	☐	Delta Dental Premiere/PPO	☐	☐	☐	☐
Vision	☐	☐	☐	☐	Vision Services Plan	☐	☐	☐	☐
EAP	☐	☐	☐	☐	Employee Assistance				
Basic Life Insurance	☐	☐	☐	☐	SunLife – See options in Section IV				
FSA	Navia – See enrollment in Section VI								
Commuter	Navia – See enrollment in Section VI								

* Employees who decline medical, dental, or vision coverage will not be able to enroll in coverage until the next open enrollment period.

**** Cash Election must read and sign below.**

*****Please note:** Monthly classified employees working less than full-time will pay for their health benefit premiums on a prorated basis. Eligible part-time instructors must use a separate form. Hourly employees are not eligible for benefits. All employees participating in medical and/or dental pay 6% or 12% of CCCCD's portion of the premium based on collective bargaining agreements.

CASH ELECTION - Only sign if option selected above.

I acknowledge that I have submitted **Evidence of Other Health Insurance Coverage** and consequently elect to waive my Health Insurance benefits through the Contra Costa Community College District. By waiving this benefit, I understand that I will receive a monthly amount in taxable earnings equal to the Kaiser single rate effective during the term of this agreement. This agreement will not be implemented until the appropriate documentation has been received and verified.

By signing this agreement, I understand the following provisions:

I. The above election may not be changed except during Open Enrollment, or upon a change in my family status such as, Marriage/Divorce, Birth/Death, or Commencement/Termination of Spouse's Employment Change in Employment Status, the employee or spouse taking an unpaid Leave of Absence, or a significant change in the Health Coverage of the Employee or Spouse.

I. Election changes must be made within 30 days of the event.

Written notification must be received in district payroll services in order to terminate this election.

Please note: Cash election will not start until the first of the month after the date of signature.

Signature - Only for Cash Election:	*Date:*

Contra Costa Community College District

Universal Benefit Enrollment/Change Form (Active Employees)

III. Dependents

Name (Last, First)	Date of Birth	SS#	Sex	Certificate		Enroll	No Change	None	IRS Qualified Dependent
Spouse			☐ M ☐ F	☐ Marriage ☐ Domestic	Medical	☐	☐	☐	If children are age **26 or over,** you must check below and fill in prior coverage below.
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
					Dep. Life*	☐	☐	☐	
1			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
					Dep. Life*	☐	☐	☐	
2			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
					Dep. Life*	☐	☐	☐	
3			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
					Dep. Life*	☐	☐	☐	
4			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
					Dep. Life*	☐	☐	☐	

*Attach separate sheet if needed. *Dependent Life as well as $50,000 Optional Plan 1 or 2 MUST be selected in the SunLife Section above in order for dependents to be eligible for life insurance coverage.*

IV. SunLife Insurance – Full-Time ONLY

Life & LTD Group/Division: 80816

Basic Life ☒ LTD — The district pays the premiums for the Basic Life and LTD if you are eligible for them. Enrollment in LTD is automatic. Long Term Disability eligibility starts on the first of the month following three months of service.

☐ Optional Life Plan 1 ☐ $50,000 *($16.90)*
(Supplemental and Extended) ☐ $100,000 *($33.80)*

The first $100,000 beyond basic life insurance is guaranteed (no questions asked) if selected within the first 30 days of hire.

Has an EOI form been submitted? ☐ Y ☐ N If **Yes**, you may select: ☐Optional Life Plan 2 $_____

Requires completing the Evidence of Insurability (EOI) form online and is subject to approval by SunLife. Maximum Election: up to five times the salary, or $400,000 (whichever is lower). Must use $25,000 increments.

Has at least $50,000 in Option 1 or 2 been selected? ☐ Y ☐ N If **Yes**, you may select: ☐Dependent Life - $5,000 ($1.32)

Only insures dependents selected above. Dependent life insurance requires enrollment in at least $50,000 of either Option Plan 1 and/or 2 beyond basic life insurance.

Primary Beneficiary(ies):

	Name:	SS#	DOB	Phone	Relationship to Employee	% Share
1						
	Address:					
2						
	Address:					

Secondary (Contingent) Beneficiary(ies):

1						
	Address:					
2						
	Address:					

V. SunLife Plan Enrollees Must Read and Sign:

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- Increases to current Life and Long-Term Disability benefits may require Evidence of Insurability.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application.
- Coverages include benefit waiting periods, limitations, and exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.
I confirm by signing below that I have minimal essential coverage (major medical coverage).

Signature Required for SunLife Plans:	*Date:*

VI. Navia

By selecting any of the options below, you authorize Contra Costa Community College District to reduce your salary by the amounts indicated below. For Plan maximums, as set by the IRS, please refer to the provided Navia handbook.

Flexible Benefits Participation

You must claim all elected funds by the end of the run-out period. After the run-out period is complete, unused Day Care FSA balances will be forfeited; this is referred to as the Use-it or Lose-it rule. Unused Health Care FSA balances will be rolled over to the subsequent plan year. Any Health Care FSA funds in excess of the rollover amount will be forfeited. In order to receive carryover, you must re-enroll in the following plan year or have a remaining balance in excess of the plan minimum.

☒ Premium Conversion — *The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.*

☐ Health Reimbursement Account: ANNUAL Health Care FSA Election $ _____

Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment. Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

☐ Dependent Daycare Account: ANNUAL Day Care FSA Election $ _____

Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description. Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503. If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the $5,000 calendar year limit mandated by the IRS.

VII. Navia FSA Enrollees Must Read and Sign:

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

☐ YES, the above benefits have been explained to me and I elect to participate as indicated.
☐ NO, the above benefits have been explained to me and I decline participation.

Signature Required for Navia Plans: *Date:*

Commuter Plan Participation

To elect this benefit, you must enroll on Navia's website. Instructions are available at www.4cd.edu/hr/benefits. The Navia folder will be on the left side. Plan information can be found by clicking on "GoNavia Commuter Booklet". Instructions for enrolling can be found by clicking "GoNavia Transit Benefit".

VIII. Anthem Enrollees Must Read and Sign:

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature Required for Anthem Plan	*Date*

IX. Kaiser Permanente Enrollees Must Read and Sign:

Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

Signature Required for Kaiser Plan	*Date*

**Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

X. Terms and Agreement (All Employees Must Sign and Date Below):

In exchange for my enrollment, I agree to notify the District in writing within 31 days of the following:

1. My change of address
2. Change to my marital status resulting in adding or deleting a spouse or domestic partner
3. Change to my eligible dependents status such as adding a newborn, or adopted child
4. Change to my ineligible dependents status such as deleting an overage dependent

I acknowledge that:

1. Enrollment is subject to post enrollment audit.
2. I have received and read the carrier information provided carefully before selecting the options above.
3. I agree to pay premiums based on my plan election. I understand and have reviewed the premiums associated with my plan elections.

Signature Required for All Plans	*Date*

XI. SHADED AREA FOR OFFICE USE ONLY

Form Reviewed & Approved By:
Processed By: