Contra Costa Community College District

Date: _____

Universal Benefit Enrollment/Change Form (Adjunct Faculty)

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

I. Employee Information

Employee Name (Last, First, Middle)			Employee ID:	
			○ Meets Eligibility Requirements	
Address (street, apartment number, city, state, zip)		*Group* ■ Faculty	*Status* ● Adjunct	*Location* ☐ CCC ☐ Dist. ☐ DVC ☐ LMC ☐ SRC ☐ BRW
Home Phone	*Cell Phone*	*Hire Date*	*SS#*	
Date of Birth	*Email Address*	*Title*		
Gender: ☐ M ☐ F	*Marital Status:* ☐ Single ☐ Married ☐ Domestic Partner	*Salary:* $	○ *Monthly* ○ *Yearly*	

II. Enrollment: ● Open Enrollment ● Other Qualifying Event: *Fill in description / 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!***

	Available To:	No Coverage	Enroll	Change in Coverage	No Change	Plan	Single	2-Party	Family	N/A
Medical	PT Faculty	☐	☐	☐	☐	Anthem/Blue Cross EPO	○	○	○	○
			☐	☐	☐	Kaiser HMO				
Dental	PT Faculty	☐	☐	☐	☐	Adjunct Delta Dental PPO	○	○	○	○
			☐	☐	☐	Adjunct DeltaCare				
Vision	PT Faculty	☐	☐	☐	☐	Vision Services Plan	○	○	○	○

Please note: Eligible part-time instructors may participate in medical, dental, and vision coverage and pay a portion of the premium.

III. Other Medical Coverage Information

Do you or your dependents have other/additional ***medical*** *care coverage? If yes, fill in the information for below.*

Name (Last, First)	Carrier Name	Group Number	Effective Date	Primary
				☐ Y ☐ N
				☐ Y ☐ N

IV. 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	☐	☐	☐	
1			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
2			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
3			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	
4			☐ M ☐ F	☐ Birth	Medical	☐	☐	☐	☐ Y ☐ N
					Dental	☐	☐	☐	
					Vision	☐	☐	☐	

Attach separate sheet if needed.

Contra Costa Community College District

Universal Benefit Enrollment/Change Form (Adjunct Faculty)

Prior PPO Coverage Information *(only applies to dependent children age 26 and over)*

If you checked "Yes" for an IRS Qualified Dependent above, fill in the section below for each dependent.

Name from above	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage

V. Section Not Used

VI. Navia

Commuter Benefits Participation (Section 132 Pre-Tax Commuter Plan)

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".

VII. 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*

VIII. SHADED AREA FOR OFFICE USE ONLY

Medical Group/ Division #: ☐ Anthem: 277996M0 ☐ Kaiser: 162-000 Effective Date: _____

Dental Group/ Division #: ☐ PT PPO: 00965-0 ☐ PT DeltaCare: 71691-0013 Effective Date: _____

VSP Group/Division#: 00104331 Effective Date: _____

Navia: Section 132 Pre-Tax Commuter Plan Effective Date: _____

Form Reviewed & Approved By:

Contra Costa Community College District
Universal Benefit Enrollment/Change Form (Adjunct Faculty)

IX. Anthem Enrollees Must Read and Sign:

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- The date eligibility for COBRA Continuation Coverage ends, or
- The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
- The date your employer discontinues coverage with Anthem Blue Cross, or
- The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
- The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end. Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

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*

Universal Benefit Enrollment/Change Form (Adjunct Faculty)

X. 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.*

XI. DeltaCare Enrollees Must Read and Sign:

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

☐ I have selected my primary care dentist and their provider number is: _____.
DeltaCare requires a primary care dentist. If no provider is selected, one will be chosen for me.

Signature Required for Delta Dental Plans	*Date*