Clear Form

2024 Employee Benefits Enrollment/Change Form

Employee ID	First Name	Last Name

Please Check The Event Type Below and Enter the Event Date Here*: _____

☐ Open Enrollment ☐ Marriage / Registered Domestic Partner ☐ Dependent Death

☐ Birth / Adoption ☐ Divorce / Legal Separation ☐ Other: _____

☐ Loss or gain of coverage for myself / dependent(s)

***Please note that you must notify HR within 31 days of your Qualifying Life Event (QLE) to make enrollment changes.** If adding a child after birth or adoption, coverage will be effective on the date of birth or adoption. All other changes will be effective on the first of the month following the event date or the date you notify us, whichever is later. Supporting documentation of the QLE is required.

Medical Plans	Level of Coverage				Action
◯ **Anthem Select HMO** PCP ID[1]# _____	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	□ New/Change □ No Change □ Waive
◯ **Anthem Priority Select HMO** PCP ID[1]# _____	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	
◯ **Anthem HDHP with HSA**	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	
Dental Plans	**Coverage**				**Action**
◯ **Cigna Basic PPO**	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	□ New/Change □ No Change □ Waive
◯ **Cigna Max PPO**	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	
◯ **Cigna Dental HMO** Dental office ID#[2]_____	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	
Vision Plan	**Coverage**				**Action**
EyeMed	□ Employee Only	□ Employee + Spouse/ Domestic Partner	□ Employee + Child(ren)	□ Employee + Family	□ New/Change □ No Change □ Waive

DEPENDENT INFORMATION

Last Name, First Name	Relationship	Gender	DOB	Social Security Number	Coverage	PCP ID#[1,2] (HMO Only)
					□ Medical □ Dental □ Vision	Medical _____ Dental _____
					□ Medical □ Dental □ Vision	Medical _____ Dental _____
					□ Medical □ Dental □ Vision	Medical _____ Dental _____
					□ Medical □ Dental □ Vision	Medical _____ Dental _____

Other Accounts	Amount Per Pay Period	Annual Amount	Action
Flexible Spending Account ***(Up to $3,050 IRS annual maximum)***	$	$	□ New/Change □ No Change □ Waive
Health Savings Account ***(Must be enrolled in Anthem HDHP)*** ***2024 IRS annual maximum:*** ***Individual = $4,150; Family = $8,300***	$	$	□ New/Change □ No Change □ Waive
Dependent Care Account ***(Up to $5,000 IRS annual maximum****;* *$2,500 if married filing separately****)***	$	$	□ New/Change □ No Change □ Waive
Limited Purpose Account *Must be enrolled in Anthem HDHP* ***(Up to $3,050 IRS annual maximum)***	$	$	□ New/Change □ No Change □ Waive

Basic Life Insurance and AD&D	EOI Requirements	Coverage
Provided by RCHSD at no cost to the employee ***Automatic Enrollment Upon Hire***	***EOI is not required***	1 x Salary

Supplemental Life Insurance	EOI Requirements	Coverage (Paid by Employee)	Action
Employee ***(Must purchase supplemental insurance for yourself to elect supplemental life for dependents)***	***Evidence of Insurability (EOI) is not required when requesting coverage up to $200k when first eligible. All other increases require EOI.***	□ 1 x Salary □ 2 x Salary □ 3 x Salary □ 4 x Salary	□ New/Change □ No Change □ Waive
Spouse ***(Max coverage is 50% of employee's total life amount)***	***Evidence of Insurability (EOI) is not required when requesting coverage up to $25k when first eligible. All other increases require EOI.***	□ $10,000 □ $25,000 □ $50,000 □ $100,000	□ New/Change □ No Change □ Waive
Child(ren) ***up to age 26***	***EOI is not required***	□ $15,000	□ New/Change □ No Change □ Waive

Long Term Disability Insurance	EOI Requirements	Coverage
Basic LTD Coverage ***Provided by RCHSD at no cost to the employee*** ***Automatic enrollment upon hire***	***EOI is not required***	40% of Monthly Earnings
Buy-Up LTD Coverage	***EOI is not required when first eligible.*** ***All other enrollments require EOI.***	□ 60% of Monthly Earnings □ No Change

BENEFICIARY DESIGNATION FOR YOUR LIFE INSURANCE

O Basic O Supplemental
O Both plans

Last Name, First Name	DOB	Relationship	Address & Phone	Primary / Contingent	Benefit Percentage

ENROLLMENT AGREEMENT / PAYROLL DEDUCTION AUTHORIZATION

I understand that if I elect to waive coverage now, I will not be permitted to enroll in the above plans (including but not limited to medical/dental/vision) until the next enrollment period (unless I have a qualifying life event). ***To cover your domestic partner, you must have a*** *state issued* ***Declaration of Domestic Partnership form on file*** *with* ***Human Resources. Contact Human Resources for details.***

I acknowledge that the above information represents my enrollment choices. I understand that by signing this form I am authorizing payroll deductions (pre-tax and after-tax) for any required contributions for the coverage(s) selected above. I further understand that my pre-tax elections cannot be changed or canceled until a future Open Enrollment period or a qualifying status change occurs. I represent to the best of my knowledge and belief, all statements and answers on this form are true, complete, and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void, and that I will be responsible for reimbursement of all claims paid for myself or my dependents during the ineligible period.

I authorize the release of my and my dependent's medical information by my health care provider(s) for the purpose of coordinating patient care, administering claims and meeting legal requirements.

I understand that any voluntary life insurance coverage that I am requesting is subject to all terms of the policy including any provisions requiring submission of Evidence of Insurability (EOI) and approval by the insurance carrier, and any provisions specifying a delayed effective date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin.

If I elect coverage through the Anthem HMO plans or the Cigna Dental HMO, I agree that except for life threatening emergencies, all medical/dental services must be performed, prescribed or authorized by my or my dependent's Primary Care Physician (PCP) or Primary Dentist. In the event a dispute arises between myself and/or my eligible dependents and my HMO or any of its providers, the same shall be settled by binding arbitration in states where applicable, as provided for in the HMO Group Agreement.

Employee Signature:_____ Date:_____

[1] Primary Care Physician (PCP) – Locate Anthem doctors at **anthem.com/ca/find-care** or call 833.913.2237.

[2] Cigna Dental Care Participating Dentist- Visit **mycigna.com** or call 800.244.6224 for assistance locating a participating dentist.

Email Form to Benefits Dept.