Santa Clara County Office of Education

DENTAL/VISION PLAN ENROLLMENT FORM

I. EMPLOYEE INFORMATION

DATE OF HIRE	DATE OF BIRTH	SOC. SEC. NO.	
LAST NAME	FIRST	MI	HOME PHONE (Including area code)
STREET ADDRESS	CITY	STATE ZIP	SEX (check) M ☐ / F ☐
Marital Status:	☐ Single ☐ Married ☐ Domestic Partner		

II. COVERAGE ELECTION (Complete dependent information section if coverage elected for spouse, children and/or domestic partner)

Delta Dental Election – PPO Plan
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Delta Dental Election – High Plan
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

Vision Election – MES
☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Employee + Family

COVERED DEPENDENT INFORMATION –Dental, Vision ☐ Add ☐ Delete

NAME	SOCIAL SECURITY NUMBER	SEX M/F	DATE OF BIRTH	Over age 18 FULL TIME STUDENT
SPOUSE / DOMESTIC PARTNER				☐ Y ☐ N
DEPENDENT #1				☐ Y ☐ N
DEPENDENT #2				☐ Y ☐ N
DEPENDENT #3				☐ Y ☐ N
DEPENDENT #4				☐ Y ☐ N
DEPENDENT #5				☐ Y ☐ N

III. PRE-TAX PREMIUM DEDUCTIONS- Section 125 Premium Only Plan

☐	**You must make an active election for each calendar year. If you enrolled in one of these plans for the current calendar year, we will not automatically re-enroll you for the new calendar year. You must re-enroll each year.** Please check this box if you ***do not*** want your premiums deducted on a pre-tax basis

IV. BENEFICIARY DESIGNATION

	BENEFICIARY- LIFE INSURANCE- STANDARD INSURANCE CO. ($20,000 CL/CE or $50,000 Leadership Team)			
Please complete an attached list if you want to name more persons than provided for on this form.	NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT
	NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF BENEFICIARY STREET/CITY/STATE/ZIP CODE			% OF BENEFIT
	IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY- NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF CONTINGENT BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT
	BENEFICIARY- BUSINESS TRAVEL ACCIDENT – MUTUAL OF OMAHA ($100,000 max) ☐ SAME AS ABOVE _____**(initial)**			
Please complete an attached list if you want to name more persons than provided for on this form.	NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT
	IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY- NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF CONTINGENT BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT
	BENEFICIARY- PERSONAL ACCIDENT- CIGNA ($1,000 basic coverage) ☐ SAME AS ABOVE _____**(initial)**			
Please complete an attached list if you want to name more persons than provided for on this form.	NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT
	IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY- NAME OF BENEFICIARY (LAST, FIRST, MI)	SSN (if known)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	PHONE # / ADDRESS OF CONTINGENT BENEFICIARY (STREET/CITY/STATE/ZIP CODE)			% OF BENEFIT

EMPLOYEE SIGNATURE X **DATE**

V. WAIVER OF BENEFITS (FOR EMPLOYEE'S THAT WORK LESS THAN .9 FTE. Check all that apply)

I hereby certify that I have been given the opportunity to participate in benefits available to me through the Santa Clara County Office of Education Benefits plan. After careful consideration, **I have decided <u>not to participate</u> in the following insurance plans and coverage:**

☐ EMPLOYEE:	☐ Medical	☐ Dental	☐ Vision	☐ Life
☐ SPOUSE OR DOMESTIC PARTNER:	☐ Medical	☐ Dental	☐ Vision	
☐ DEPENDENT CHILDREN:	☐ Medical	☐ Dental	☐ Vision	

REASON FOR DECLINING THIS COVERAGE *(Must be completed)*:

I have other medical insurance coverage ☐ Yes ☐ No

I understand I will not be able to enroll in these benefits again until:

_____ **(initial)** I contact an Employee Benefits Specialist and complete the required forms during the open enrollment period.

_____ **(initial)** I lose my other medical insurance coverage

AUTOMATIC WAIVER FOR PART-TIME EMPLOYEES: YOU HAVE NOT COMPLETED THE NECESSARY FORMS FOR FRINGE BENEFIT ENROLLMENT WITHIN THE 30 DAY PERIOD FROM YOUR DATE OF HIRE AS SPECIFIED IN YOUR OFFER LETTER. YOU WILL HAVE THE OPPORTUNITY TO ENROLL AGAIN AS SPECIFIED ABOVE AND MAY HAVE TO PROVIDE SATISFACTORY MEDICAL EVIDENCE OF INSURABILITY TO BE COVERED AT A LATER DATE

If you work less than full-time and receive less than the amount that is contributed towards a full-time employee, you may decline coverage. If you are waiving coverage under *Santa Clara County Office of Education's Benefits* plan because you and your dependent(s) have coverage under another employer's benefit plan, please indicate that above.

I understand that I am being offered the opportunity to enroll in affordable, comprehensive health insurance coverage through my employment with the Santa Clara County Office of Education. I understand that as of January 1, 2014, I am required by law to maintain an acceptable level of health insurance coverage for myself and my dependents.

WAIVER OF COVERAGE AGREEMENT:

By signing this form I have agreed to waive my employer-paid benefits. I understand that unless I experience a qualifying event as defined by the IRS, I will not be allowed to enroll in coverage or make changes to my selection until the next open enrollment period.

EMPLOYEE SIGNATURE X _____ **DATE** _____

VI. RELEASE

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs in excess of the amounts payable under the plan.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO ALL SECTIONS AND THE TERMS OF THIS ENROLLMENT FORM.

EMPLOYEE SIGNATURE X _____ **(Required) DATE** _____

TO BE COMPLETED BY SANTA CLARA COUNTY OFFICE HUMAN RESOURCES ONLY

- ☐ **Change** — **Qualifying Event:**_____
- ☐ **New Hire** — **Qualifying Event Date:** _____
- ☐ **Open Enrollment** — **Effective Date:**_____

Medical Insurance	Date Entered	Delta Dental	Date Entered
QCC Updates	Date Entered	Vision	Date Entered