# SEIU Local 1021 – Child Care Employees



### 2019 Flexible Benefit Plan Election Form

Please submit this form ONLY if you are making changes to your enrollment or if you are enrolling for the first time. If you have questions on how to complete the form, please contact HR at 485-3391 or [human.resources@cityofsanrafael.org](mailto:human.resourcces@cityofsanrafael.org). Flex dollar allowances and premium rates are for 2019, however since CalPERS requires prepayment of premiums, the scheduled rate increases go into effect in December of 2018 (for January 2019 coverage).

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| Last Name: | | |  | | | First Name: | | |  | | |
| Address: | |  | | | | | City: |  | | Zip: |  |
| Phone: |  | | | E-mail: |  | | | | | | |

**I would like to make the following change to my health enrollment effective Jan 1, 2019** *(choose one)***:**

*Please complete Sections 1-3 below. You will need to complete a CalPERS Health Enrollment form (available on the HR intranet at* [*https://intranet.cityofsanrafael.org/hr/default.aspx*](https://intranet.cityofsanrafael.org/hr/default.aspx)*) and supply the required documentation as noted in your selection below.*

* Enroll in Health *(requires birth/marriage cert or Declaration of Domestic Partnership if enrolling dependents)*
* Change Health Plan
* Add Dependent *(requires birth/marriage cert or Declaration of Domestic Partnership)*
* Delete Dependent *(if applicable, requires Divorce Decree or Termination of Domestic Partnership)*
* Decline/Cancel Coverage *(requires signed Waiver of Coverage form)*

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| --- | --- | --- | --- | --- |
| **Section 1 - Determine Flex Dollar Allowance** (complete appropriate line only) | | | | |
| I am electing Coverage for: | EE Only - $745.00 | EE+1 - $1,087.68 | EE+Family - $1,115.49 | |
| I am part-time \_\_\_\_%FTE & hired on or after 1/1/10 *(Enter prorated amount)* | | | | \_\_\_\_\_\_\_\_\_ |
| I am part-time \_\_\_\_% FTE & hired **prior to 1/1/10** *(Enter prorated amount)*  *If electing “EE Only” coverage pro-rate based off $909; the maximum benefit is $650 per month* | | | | \_\_\_\_\_\_\_\_\_ |
| I am waiving medical coverage *(Enter* ***$300****, or prorated amount based on FTE)* | | | | \_\_\_\_\_\_\_\_\_ |

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| **Section 2 - Select Medical Coverage** | |  | **EE only** |  | **EE + 1** |  | **EE + Family** |
| Be sure to check www.calpers.ca.gov to see which plans are offered in your specific zip code. | Anthem HMO Select |  | $ 831.44 |  | $ 1,662.88 |  | $ 2,161.74 |
| Anthem HMO Traditional |  | $ 1,111.13 |  | $ 2,222.26 |  | $ 2,888.94 |
| Blue Shield (BSC) Access+\* |  | $ 970.90 |  | $ 1,941.80 |  | $ 2,524.34 |
| HealthNet SmartCare |  | $ 901.55 |  | $ 1,803.10 |  | $ 2,344.03 |
| Kaiser CA |  | $ 768.25 |  | $ 1,536.50 |  | $ 1,997.45 |
| PERS Choice |  | $ 866.27 |  | $ 1,732.54 |  | $ 2,252.30 |
| \***Blue Shield (BSC) Access+ WILL NOT** be available in some Bay Area Counties (including Alameda, Contra Costa, Marin & Sonoma) | PERS Select |  | $ 543.19 |  | $ 1,086.38 |  | $ 1,412.29 |
| PERS Care |  | $ 1,131.68 |  | $ 2,263.36 |  | $ 2,942.37 |
| Western Health Advantage |  | $ 767.01 |  | $ 1,534.02 |  | $ 1,994.23 |

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| --- | --- |
| **Section 3 Total Flex Dollar Amount** | |
| **Enter Total Flex Dollar Allowance from Section 1** | $ |
| **Enter Medical Coverage Election Amount from Section 2** | $ |
| **Subtract Line 2 from line 1.** If total is less than zero, the amount shown will be a deducted from your paycheck (per month). If the total is greater than zero, you will receive this amount in taxable income (“cash back”). | $ |

*I understand that by signing and submitting this Flexible Benefit Plan form I am making a binding election for a plan year for my benefits and am authorizing a pre-tax payroll deduction from my earnings. I understand that if I decline the above coverage, I cannot change my mind during the plan year and elect coverage, unless I experience a change in status.*

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**