



SEIU Local 1021

2020 Flexible Benefit Plan Election Form

Region 1 - to see a full list of counties please visit <https://www.calpers.ca.gov/docs/2020-health-rates-region-1.pdf>. Please submit this form **ONLY** if you are making changes to your enrollment or if you are enrolling for the first time. **Flex dollar allowances and premium rates are for 2020, however since CalPERS requires prepayment of premiums, the scheduled rate increases go into effect in December of 2019 (for January 2020 coverage).**

Full Name: _____ Department: _____

I would like to make the following change to my health enrollment effective Jan 1, 2020 (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://employees.cityofsanrafael.org/benefits/>) 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)

Section 1 - Determine Flex Dollar Allowance (complete appropriate line only)	
I am electing Coverage for:	<input type="checkbox"/> EE Only - \$758.18 <input type="checkbox"/> EE+1 - \$1,434.17 <input type="checkbox"/> EE+Family - \$ 1,571.56
I am part-time _____%FTE & hired on or after 1/1/10 (Enter prorated amount)	<input type="checkbox"/> _____
I am part-time _____% FTE & hired prior to 1/1/10 (Enter prorated amount) <small>If electing "EE Only" coverage pro-rate based off \$1,264; the maximum benefit is \$700 per month</small>	<input type="checkbox"/> _____
I am waiving medical coverage (Enter \$300 , or prorated amount based on FTE)	<input type="checkbox"/> _____

Section 2 - Select Medical Coverage		EE only		EE + 1		EE + Family
	<input type="checkbox"/>	\$ 861.18	<input type="checkbox"/>	\$ 1,722.36	<input type="checkbox"/>	\$ 2,239.07
	<input type="checkbox"/>	\$ 868.98	<input type="checkbox"/>	\$ 1,737.96	<input type="checkbox"/>	\$ 2,259.35
	<input type="checkbox"/>	\$ 1,184.84	<input type="checkbox"/>	\$ 2,369.68	<input type="checkbox"/>	\$ 3,080.58
*Blue Shield Access+, Blue Shield EPO, Blue Shield Trio & United Healthcare are now available.	<input type="checkbox"/>	\$ 1,127.77	<input type="checkbox"/>	\$ 2,255.54	<input type="checkbox"/>	\$ 2,932.20
	<input type="checkbox"/>	\$ 1,127.77	<input type="checkbox"/>	\$ 2,255.54	<input type="checkbox"/>	\$ 2,932.20
	<input type="checkbox"/>	\$ 833.00	<input type="checkbox"/>	\$ 1,666.00	<input type="checkbox"/>	\$ 2,165.80
	<input type="checkbox"/>	\$ 1,000.52	<input type="checkbox"/>	\$ 2,001.04	<input type="checkbox"/>	\$ 2,601.35
	<input type="checkbox"/>	\$ 768.49	<input type="checkbox"/>	\$ 1,536.98	<input type="checkbox"/>	\$ 1,998.07
	<input type="checkbox"/>	\$ 861.18	<input type="checkbox"/>	\$ 1,722.36	<input type="checkbox"/>	\$ 2,239.07
	<input type="checkbox"/>	\$ 520.29	<input type="checkbox"/>	\$ 1,040.58	<input type="checkbox"/>	\$ 1,352.75
	<input type="checkbox"/>	\$ 1,133.14	<input type="checkbox"/>	\$ 2,266.28	<input type="checkbox"/>	\$ 2,946.16
	<input type="checkbox"/>	\$ 899.94	<input type="checkbox"/>	\$ 1,799.88	<input type="checkbox"/>	\$ 2,339.84
	<input type="checkbox"/>	\$ 731.96	<input type="checkbox"/>	\$ 1,463.92	<input type="checkbox"/>	\$ 1,903.10

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 <u>less</u> than zero, the amount shown will be a deducted from your paycheck (per month). If the total is <u>greater</u> 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:** _____