Medical Enrollment Form

Website _____
HRS _____

Open Enrollment 2024 Health Benefits Plan Enrollment for Active Employees (HBD-12)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

SECTION A: Applicant Information

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*

2. **Hire Date:** (mm/dd/yyyy) **N / A**

3. **CalPERS ID or Social Security Number:**

4. **Date of Birth:** *(mm/dd/yyyy)*

5. **Gender:** ☐ Male ☐ Female

6. **Residence Address:** *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

7. **Mailing Address** (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

8. **Use Work ZIP Code for Health Eligibility**: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*

9. **E-mail Address:**

10. **Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: _____ ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:

13. **Permitting Event Date**: (mm/dd/yyyy) **N / A**

14. **Name of Health Plan**:

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents to be enrolled on your health plan)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	
		☐ Male ☐ Female			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. **To enroll, carefully review the information in this section and check the box:**

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and 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 provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, 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.

17. **To decline, carefully review the information in this section and check the box:**

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

18. **Employee Signature:**

19. **Date:** *(mm/dd/yyyy)*

Bar Code Placeholder

Dental
Enrollment Form

DELTA DENTAL®

Website _____

HRS _____

OPEN ENROLLMENT 2024
ENROLLMENT/CHANGE FORM - CA
DUAL CHOICE

www.deltadentalins.com

Select a Plan: ❑ **PPO Fee-For-Service** P.O. Box 429086 San Francisco, CA 94142-9086 **OR** ❑ **HMO** DeltaCare® USA[1] P.O. Box 1803 Alpharetta, GA 30023

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State

Effective Date / /	Hire Date / /

Name of Employer

Location	Pay Code	Benefit Package

Enrollee/Change Information

❑ New Enrollment ❑ Address Change ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Terminate Enrollee Coverage

❑ Marital Status Change ❑ Change Dental Plans*

Change Dental Plan*

❑ **Fee-For-Service - Cancel**

❑ **DeltaCare USA - Cancel**

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contra ct.

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified

❑ Part-Time ❑ Salaried ❑ Classified

❑ Retired ❑ Member/Other _____

COBRA (if applicable)

❑ Termination

❑ Reduction in Hours

❑ Divorce/Legal Separation**

❑ Widowed/Surviving Dependent**

❑ Dependent Child No Longer Eligible**

Indicate qualifying date: ____/____/____

If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth / /	Gender ❑ Male ❑ Female	Marital Status ❑ Single ❑ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	Zip Code

E-mail Address (internal use only)	Phone Number ( ) -	Phone Type Cell ❑ Work ❑ Home ❑

Network Facility Name (DeltaCare USA only)	Network Facility Number (DeltaCare USA only)

Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth / /

Effective Date of Other Policy / /	Policy Holder Street Address	City	State	Zip Code

Dependent Information

Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled***	Name of School (overage student)***	Network Facility Number ‡ (DeltaCare USA only)
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑		

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Addi tional documentation will be required for disabled and student st atus. ‡Maximum of three facilities per family.

❑ 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 decline coverage at this time.

Signature of Enrollee _____ Date ____/____/____

[1]DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enr ollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

Vision
Enrollment Form

Website _____
HRS _____

FOR INTERNAL USE ONLY

_____ Classified _____ Certificated

_____ Management

Effective Date: _____

Open Enrollment 2024
VSP Enrollment Form

Name: _____ Social Security: _____

Address: _____ Date of Birth: _____

City, State, Zip _____ _____ Male _____ Female

Home Phone: _____ Cell Phone: _____

PLEASE LIST ELIGIBLE DEPENDENTS TO BE COVERED:

Name: _____ Date of Birth: _____ Gender M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Name: _____ Date of Birth: _____ M☐ F☐ Relationship: _____

SSN: _____

Signature of Enrollee: _____ Date: _____

Pre-tax Form

BURBANK UNIFIED SCHOOL DISTRICT

PRETAX PAYROLL DEDUCTIONS

Currently some employees have payroll deductions taken for health care (medical, dental, and vision), depending on their coverage election coverage or their status at the District (less than full time).

The District and the associations have been investigating ways to reduce the impact of these deductions on employees' paychecks. Effective August 1, 1993, the District, with the support of CSEA, BTA, and BASA, is permitting employees who have payroll deductions taken to have the deduction taken on a pretax basis, which will increase the take home pay over the current payroll deduction method.

The District now takes payroll deductions in this order:

- First, taxes are taken out of your gross pay
- Second, payroll deductions are taken for health care

But it works this way with pretax payroll deductions:

- First, payroll deductions are taken for health care
- Second, taxes are computed on your pay after it has been reduced for health care contributions

Because you are taxed on a lower amount of pay, you save money. Here's an example for an employee spending $100 tenthly ($1,000 annually) for health care:

	Current Deduction Method	Pretax Deductions
Annual Earnings	$8000	$8000
Pretax Deductions	N/A	-$1000.00
Taxable Earnings	$8000	$7000
Income Taxes and Social Security	$1146	$961
Normal Deduction	$1000	N/A
Take Home Pay	$5854	$6039
Savings		$185

In this case, take home pay for this employee goes up by $185, which amounts to a 3% increase. Yet, the employee will have the same health benefits. Participation in this program does not change any disability, life insurance, or retirement benefits you may otherwise be entitled to. Because you pay less Social Security, your ultimate Social Security benefit may be slightly lower after retirement. Generally speaking, however, the benefit of the tax savings now more than outweighs the reduction in Social Security benefit after you retire. Please discuss your specific financial situation with a tax consultant prior to submitting this form.

This program is voluntary—you don't have to sign up. For most of you, however, it is an opportunity to take home more cash. Due to **IRS** rules, we can only let you come in once a year on our plan anniversary (January 1). Once you begin participation, you can only drop out during a given school year if you have a change in family status as defined by the Internal Revenue Service (birth or death of a dependent, marriage or divorce, spouse loses or gets a job).

EMPLOYEE AUTHORIZATION

_____YES (Pretax Basis), I_____ request to participate in Burbank Unified School District's

_____NO (Pretax Basis), I_____ do not request to participate in Burbank Unified School District's

benefit plan. I hereby authorize reductions in my salary to cover my share of the cost, as indicated by the above elections. I understand that by signing and submitting this form**, I am making a binding election concerning these benefits for the twelve-month period beginning January 1, 2024 and ending December 31, 2024.** Changes in benefit elections may only be made for certain changes in family status as allowed by the Burbank Unified School District's plan document and the underlying health plan. **Pretax payroll deductions require annual sign up.**

Certificated ( ) **Classified ( )** **Management ( )** **Social Security number** **_XXX-_XX_-_____**

_____

Print Name

_____ _____

Signature **Date**