

# Health Insurance Enrollment/Change Form

Return completed form and required attachments to:  
 City of Stockton – Human Resources (HR) Department  
 400 E. Main Street, 3<sup>rd</sup> Floor, Stockton, CA 95202  
 Phone: (209) 937-8233, Fax: (209) 937-5702

HR USE ONLY

Entered: \_\_\_\_\_

Verified: \_\_\_\_\_

## ENROLLMENT/CHANGE REASON

NEW HIRE   
  OPEN ENROLLMENT   
  QUALIFYING LIFE EVENT\*   
  COURT ORDERED   
 EFFECTIVE DATE \_\_\_\_\_  
 (Will be verified by HR staff)

## EMPLOYEE INFORMATION

Last Name	First Name, MI <span style="float: right;"><input type="checkbox"/> Female <input type="checkbox"/> Male</span>
Social Security Number	Date of Birth
Street Address or P.O. Box	City/State/Zip
Home Phone	Cell Phone
E-mail Address	Bargaining Unit

## DEPENDENTS — Please list Spouse/Registered Domestic Partner (RDP) and Children below.

Action	Full Name	Relationship	Date of Birth	Social Security #	F/M	(If Applicable, for Child)
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP
<input type="checkbox"/> Add <input type="checkbox"/> Delete						<input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Married/RDP

**\*Note:** Proper and timely receipt of documentation is required when adding or removing dependents from a qualifying life event, such as: Birth, marriage, registered domestic partnerships, divorce, adoption, legal guardianship, Qualified Medical Child Support Order (QMCSO), etc. If you have a current QMCSO, you must provide verification from the issuing agency before making any changes to the health insurance benefits of the child(ren) named on the QMCSO.

Documentation must be received in a timely manner to receive benefits. You are required to submit documents **within 31 days** of the qualifying life event, and **benefits will begin the first of the month following the date all required documents have been received.** Please refer to the appropriate plan document and City directive for specific eligibility requirements. A dependent child between the age of 19 through his or her 23<sup>rd</sup> birthday is eligible for dental and vision coverage only if he or she is a full-time college student (12+units) and unmarried. It is the employee's responsibility to submit proof of full-time student status **each** semester to maintain these benefits for the dependent.

# Health Insurance Enrollment/Change Form

HR USE ONLY

Name:	ABT:	Effective:
-------	------	------------

### MEDICAL OPT OUT ACKNOWLEDGEMENT (if applicable)

I decline medical and prescription coverage.\*

\*By checking this box and signing this form, you are acknowledging that you were offered medical and prescription coverage through the City of Stockton for you and your eligible dependents, and you have declined to enroll in this coverage. You may still enroll in dental and/or vision coverage below. If you are married to, or a dependent of, a City of Stockton employee, you cannot have double coverage on medical, dental, and vision plans offered by the City of Stockton.

### CITY OF STOCKTON HEALTH PLAN OPTIONS AND MONTHLY EMPLOYEE CONTRIBUTION RATES

Health plans listed below are offered to employees of all represented and unrepresented groups, however, employee contributions are determined through the collective bargaining process. If you elect a Kaiser or Sutter plan, you must also complete an additional provider enrollment form. The amounts listed below represent the employee contribution only, not the full premium cost.

#### **MEDICAL: SELECT ONE PLAN IN YOUR BARGAINING UNIT**

#### **B&C, FIRE, FIRE MGMT, SCEA, SPMA, SPOA, O&M, T&M, UNREP, WATER SUPS**

	MODIFIED	NEW: KAISER HMO (NO DEDUCTIBLE)	NEW: SUTTER HEALTH PLUS HMO	KAISER DEDUCTIBLE PLAN
EE Only	<input type="checkbox"/> \$217.92	<input type="checkbox"/> \$176.66	<input type="checkbox"/> \$122.53	<input type="checkbox"/> \$ 68.80
EE + 1	<input type="checkbox"/> \$393.96	<input type="checkbox"/> \$319.43	<input type="checkbox"/> \$222.75	<input type="checkbox"/> \$125.28
EE + Fam	<input type="checkbox"/> \$526.06	<input type="checkbox"/> \$424.81	<input type="checkbox"/> \$296.66	<input type="checkbox"/> \$165.96

#### **DENTAL: SELECT ONE PLAN OR OPT OUT OF COVERAGE**

DELTA DENTAL	PPO (Wide Network)	DHMO (Limited Network)
EE Only	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
EE + 1	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00
EE + Fam	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$0.00

#### **VISION: SELECT ONE PLAN OR OPT OUT OF COVERAGE**

VSP	BASIC	BUY UP
EE Only	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$3.00
EE + 1	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$5.00
EE + Fam	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$7.00

Opt Out of Dental Coverage

Opt Out of Vision Coverage

### OPERATING ENGINEERS' (OE3) HEALTH PLAN OPTIONS AND MONTHLY EMPLOYEE CONTRIBUTION RATES

Health Plans listed below are offered to members of the Operating Engineers' Local Union (OE3) only. Dental and vision benefits for the plans below are administered by OE3. Dental and vision rates are included in the rates below. If you elect an OE3 health plan, you must also complete a separate OE3 Enrollment Form and/or Kaiser Enrollment Form for Kaiser A & B, if applicable.

#### **TRADES & MAINTENANCE: SELECT ONE PLAN (if applicable)**

	INDEMNITY A	INDEMNITY B	INDEMNITY C	INDEMNITY D	KAISER A	KAISER B
EE Only	<input type="checkbox"/> \$222.44	<input type="checkbox"/> \$204.44	<input type="checkbox"/> \$102.44	<input type="checkbox"/> \$ 83.44	<input type="checkbox"/> \$287.44	<input type="checkbox"/> \$229.44
EE + 1	<input type="checkbox"/> \$531.44	<input type="checkbox"/> \$496.44	<input type="checkbox"/> \$291.44	<input type="checkbox"/> \$254.44	<input type="checkbox"/> \$661.44	<input type="checkbox"/> \$545.44
EE + Fam	<input type="checkbox"/> \$729.44	<input type="checkbox"/> \$681.44	<input type="checkbox"/> \$405.44	<input type="checkbox"/> \$354.44	<input type="checkbox"/> \$824.44	<input type="checkbox"/> \$674.44

#### **OPERATIONS & MAINTENANCE AND WATER SUPERVISORY: SELECT ONE PLAN (if applicable)**

	INDEMNITY A	INDEMNITY B	INDEMNITY C	INDEMNITY D	KAISER A	KAISER B
EE Only	<input type="checkbox"/> \$232.44	<input type="checkbox"/> \$214.44	<input type="checkbox"/> \$112.44	<input type="checkbox"/> \$ 93.44	<input type="checkbox"/> \$297.44	<input type="checkbox"/> \$239.44
EE + 1	<input type="checkbox"/> \$541.44	<input type="checkbox"/> \$506.44	<input type="checkbox"/> \$301.44	<input type="checkbox"/> \$264.44	<input type="checkbox"/> \$671.44	<input type="checkbox"/> \$555.44
EE + Fam	<input type="checkbox"/> \$739.44	<input type="checkbox"/> \$691.44	<input type="checkbox"/> \$415.44	<input type="checkbox"/> \$364.44	<input type="checkbox"/> \$834.44	<input type="checkbox"/> \$684.44

**INELIGIBLE CLAIMS OR PREMIUMS ACKNOWLEDGEMENT:** In the event that the City of Stockton pays medical, dental, and/or vision claims or premiums for an ineligible dependent, the employee will be required to refund the City for the full cost of the claim and/or premium paid. This may occur when there has been a change in the marital/registered domestic partnership status, or change in a dependent's full-time student status, not reported to the City of Stockton's Human Resources Department Benefits Division. **By signing below, I certify that the information provided herein is true and accurate to the best of my knowledge, and I understand all of the acknowledgements and disclaimers listed in this document.**

**PAYROLL DEDUCTIONS:** Health benefit contributions (if applicable) will be deducted pre-tax from each paycheck under the City of Stockton's Section 125 Plan umbrella. The employee may specifically request a post-tax deduction by providing a written statement, under separate cover. By signing below, you are authorizing the City of Stockton to deduct pre-tax payroll contributions for health benefits. This deduction is based on the cost of benefits as established by the Health Actuarial Report minus the employer's contribution. Upon separation of employment, if the final paycheck is not enough to cover the health premiums, the City will bill the employee for the amount due or terminate benefits retroactively.

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