Culver CITY®

HUMAN RESOURCES

Reset Form

BENEFITS ENROLLMENT/CHANGE ELECTION FORM:

Please complete this document to initiate benefits enrollment or for change in status event changes. This form must be received in Human Resources within 60 days from your hire date or qualifying event date for processing. Questions? Please e-mail CC_Benefits@culvercity.org or call 310.253.5640.

SECTION A: TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT OR TYPE)

Employee ID:	Name (First, M, Last):	Email Address:	Phone Number:

Department
Economic Development

Marital Status (Check One): ☐ Single ☐ Married ☐ Domestic Partnership

Gender: ☐ Male ☐ Female ☐ Non-Binary

Mailing Address (include city, state, and zip code):

ACTIONS TO BE TAKEN: ☐ **New enrollment** ☐ **Open enrollment** ☐ **Changes Due to Change in Status Event**

*Permitting Event Date: _____ Describe the event _____ (i.e., newborn, marriage, divorce)

HEALTH PLANS:

When enrolling in an HMO plan you must select a Primary Care Physician for yourself and each enrolled dependent. Please call your health plan's Customer Service and provide them this information.

☐ **Anthem Blue Cross Traditional** (855-839-4524)
☐ **Anthem Blue Cross Select HMO California** (855-839-4524)
☐ **Blue Shield Access+** (800-334-5847)
☐ **Blue Shield Trio** (800-334-5847)

Health Maintenance Organization (HMO)

☐ **Health Net Salud y Mas** (888-926-4921)
☐ **Health Net SmartCare** (888) 926-4921
☐ **Kaiser Permanente** (800-464-4000)
☐ **Sharp Performance Plus (San Diego County Residents)** (855-839-4524)
☐ **United Healthcare Alliance** (877-359-3714)
☐ **United Healthcare Harmony** (877-359-3714)

Preferred Provider Organization (PPO)

Blue Shield (855) 633-4436 — ☐ **PERS Gold** ☐ **PERS Platinum**

☐ **PORAC PPO**
Sworn Police and Fire Only (800-937-6722)

DENTAL PLANS: ☐ **Delta Dental PPO** ☐ **DeltaCare USA HMO** _____

If you are enrolling in Delta Care USA HMO, please provide name of dentist and provider — Name of DeltaCare USA DENTIST & Provider Number

MEDICAL INSURANCE OPT- OUT: CASH ALLOWANCE IS BASED ON EMPLOYEE ONLY $921/MONTH

If opting out, you must provide Name, Policy or Group Number and Proof of Current Alternative Health Coverage Status

Name of Health Plan	Policy or Group Number

Spouse's /Domestic Partner's Social Security Number: _____

** If alternate insurance is provided through your spouse's or domestic partner's, please provide their social security number.*

LIST OF ELIGIBLE DEPENDENTS AND SELECTION OF BENEFITS ENROLLMENT:

Please list all eligible dependents to be enrolled, including yourself. Provide HR the appropriate documents to verify your dependents (i.e., marriage certificate, proof of domestic partnership, birth certificate, Social Security Number (SSN), etc.).

					HEALTH		DENTAL		VISION	
Name	Birth Date	Gender	Relationship Code	SSN	Add	Delete	Add	Delete	Add	Delete
		Non-binary	SELF							
		Non-binary								
		Non-binary								
		Non-binary								
		Non-binary								
		Non-binary								

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 (1) 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 and in the City of Culver City Benefits Guide. **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.

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents. I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90-day waiting period or the OE effective date.

EMPLOYEE SIGNATURE: **DATE:**

CULVER CITY BENEFITS ENROLLMENT/CHANGE FORM

HOW TO ENROLL IN FLEXIBLE SPENDING ACCOUNT

For new hires and change in status events only, employees can enroll in the health and/or dependent care flexible spending plan by completing the electronic enrollment form. Please note that the Annual FSA enrollment is completed through Employee Self Service (ESS) during Open Enrollment.

HOW TO ENROLL IN THE DEFERRED COMPENSATION 457 PLAN

Complete the electronic 457 Deferred Comp Change form to enroll and select your contributions. The electronic change form should also be used to make future contribution changes.

Email mflores@missionsq.org or call (202) 759-7162 to schedule a virtual appointment with MissionSquare's Retirement Plan Specialist.

HOW TO ENROLL IN VOLUNTARY BENEFITS PLAN(S)

You will receive an email from Employee Navigator as a new hire and you may elect which voluntary benefit plans you wish to enroll in. Please note that the Annual Voluntary Life enrollment is completed through Employee Self Service (ESS) during Open Enrollment.

ADDITIONAL CALPERS NOTIFICATIONS

CalPERS Privacy Notice
The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status. Please do not include information that is not requested.

SSN
Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

INITIAL HERE TO ACKNOWLEDGE CALPERS NOTIFICATION: _____

THIS SECTION IS FOR HUMAN RESOURCES STAFF ONLY

Date of Hire: (mm/dd/yyyy)	**CalPERS ID:**	**Employee Bargaining Unit:**
Date Received by Employer:		**Insurance Effective Date:**
Health Benefits Officer: (Print name)	**Signature:**	**Date:** (mm/dd/yyyy)
Notes:		