NEW HAVEN UNIFIED SCHOOL DISTRICT

INSURANCE AGREEMENT AUTHORIZATION

2018-2019 Plan Year Rates effective October, 2018-September, 2019

EMPLOYEE NAME:_____ SITE:_____ SSN: XXX-XX-_____

You are hereby authorized and directed to deduct from my earnings each month sufficient monies to provide for the insurance coverage specified below. In the event the amount specified changes, you are authorized to increase or decrease the amount deducted. Please note: Delta Dental is **mandatory** for all full-time employees, except those whose spouses are employed by the district and have already subscribed.

For Certificated and Management employees: Please be aware that your Health and Welfare allotment has already been included in your salary. Therefore, selecting one or more of the plans below will result in a deduction from your pay warrant.

SECTION I – PLAN SELECTION (see reverse for required documentation) Please note: rates are annualized

☐	**DELTA DENTAL**	Composite Coverage, $107.20		
☐	**ANTHEM HMO SELECT**	☐Single, $702.43	☐2-Party, $1,540.11	☐Family, $2,042.72
☐	**ANTHEM HMO TRADITIONAL**	☐Single, $929.47	☐2-Party, $1,994.18	☐Family, $2,633.01
☐	**BLUE SHIELD ACCESS+**	☐Single, $815.18	☐2-Party, $1,765.61	☐Family, $2,335.87
☐	**HEALTH NET SMARTCARE**	☐Single, $756.78	☐2-Party, $1,648.82	☐Family, $2,184.04
☐	**KAISER**	☐Single, $635.90	☐2-Party, $1,407.06	☐Family, $1,869.76
☐	**PERS CHOICE**	☐Single, $714.52	☐2-Party, $1,564.29	☐Family, $2,074.15
☐	***PERS SELECT**	☐Single, $451.52	☐2-Party, $1,038.29	☐Family, $1,390.34
☐	**PERS CARE**	☐Single, $934.12	☐2-Party, $2,003.50	☐Family, $2,645.12
☐	**Western Health Advantage**	☐Single, $638.15	☐2-Party, $1,411.55	☐Family, $1,875.59

***not available in Alameda County**

☐ **I ELECT ENROLLMENT IN THE DISTRICT MEDICAL AND/OR DENTAL PLANS**

EFFECTIVE _____ 1, 201___.

☐ **I DECLINE ENROLLMENT IN ANY OF THE DISTRICT MEDICAL PLANS**

SECTION II – SECTION 125 PLAN

☐ **ENROLL**: I wish to reduce my taxes by having my premiums deducted through the section 125. I have read the information regarding the plan on the reverse side of the form and understand and agree to the conditions.

☐ **DO NOT ENROLL:** I do not wish to enroll in the section 125 plan.

SIGNATURE By signing this form I affirm that I have read, understand and agree to all terms and conditions associated with the District health plans.

_____ _____

Signature Date

SECTION 125 PLAN

Employees that pay a portion or all of their medical premiums can elect to pay their premiums through the Section 125 plan. Employees can only opt in and out of the Section 125 plan during open enrollment. Please note that participation in the Section 125 plan reduces Social Security and Medicare taxes as well as federal and state taxes.

How does the 125 plan work?
When you elect to participate in the 125 plan, the premiums you pay for your medical and/or dental plan are deducted before payroll taxes are applied to your earnings. Since you are paying taxes on a smaller amount of earnings, you pay less in taxes.

If I sign up for the 125 plan can I still use my premiums as a deduction on my income taxes?
No, since you are not paying tax on the earnings used to pay your premiums, you cannot deduct them from your income taxes.

If I sign up for the 125 plan, can I drop my coverage/switch my coverage/make changes to my coverage anytime?
If you elect the 125 plan you will only be able to make changes to your plan selections during open enrollment or within 30 days of a qualifying event. If you have a qualifying event, as defined by the IRS, you can make changes to your medical plan within 30 days of the qualifying event, whether or not you participate in the Section 125 plan. At the time of the qualifying event, you also have the ability to opt in or out of the Section 125 plan. If the qualifying event is a spouse's loss of medical coverage, written confirmation must be provided detailing the effective date of the loss of coverage.

What is a qualifying event?
A qualifying event is a change in the participating employee's family status such as: marriage, divorce, birth or adoption of a child, death of a spouse or dependent, spouse's change of employer, etc.

REQUIRED DOCUMENTS (to be provided to NHUSD)

If adding a dependant child: A copy of the child's passport, birth certificate and/or adoption certificate showing the relationship of the child to the employee and the child's date of birth. If the child is a legal ward of the employee, a copy of court documents is required.

If adding a spouse: a copy of the marriage certificate.

If adding a domestic partner: a copy of the California Certificate of Registration of Domestic Partnership.

CalPERS

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)
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)
14. **Name of Health Plan**: (If changing health plans, list new plan name)

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.

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.

18. **Employee Signature:**
19. **Date:** *(mm/dd/yyyy)*

SECTION F: 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
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).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

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.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

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.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. **Agency Name:**	21. **Date of Hire**: *(mm/dd/yyyy)*	22. **Retirement System**: ☐ CalPERS ☐ CalSTRS ☐ Other
23. **CalPERS Employer ID:**	24. **Division ID:**	25. **Employee Bargaining Unit/Employee Group:**
26. **Payroll Office:** ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	27. **Date Received by Employer:**	28 **Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. **Health Benefits Officer:** (Print name)	30. **Signature:**	31. **Date:** *(mm/dd/yyyy)*	32. **Phone Number:**

33. **Remarks:**

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Please do not include information that is not requested.

Social Security Numbers

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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 CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

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Declaration of Health Coverage: HBD-12A (INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER ___-___-___	NAME (FIRST) _____ (MIDDLE) _____ (LAST) _____

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90-day waiting period or the Open Enrollment effective date.
PART B-2 ☐ I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature _____ Date Signed _____ Health Benefits Officer's Signature _____

INSTRUCTIONS – DECLARATION OF HEALTH COVERAGE (HBD-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HBD-12A.	
Employee Information	Complete with the appropriate employee information.
Part A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
Part B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage
Part B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
Part C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
Part C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

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

Special rules to consider for retirement and death:

Retirees: you are eligible to enroll in a CalPERS health plan if you meet all of the criteria below:

- Your retirement date is within 120 days of separation from employment
- You are eligible for health benefits upon separation
- You receive a monthly retirement allowance
- You retire from the State, California State University (CSU), or an agency that currently contracts with CalPERS for health benefits

Survivor Death Benefit: your dependents may enroll in a CalPERS health plan as a survivor as long as they:

- Are eligible for enrollment as a dependent on the date of death of a CalPERS retiree
- Receive a monthly survivor check
- Continue to qualify as an eligible family member

Dependents who are enrolled at the time of the employee or annuitant's death and meet the eligibility requirements can continue the health enrollment as a survivor. Dependents who are not enrolled and meet the eligibility requirements may enroll in a health plan within 60 days of the employee or annuitant's death, or during Open Enrollment.

The effective date of enrollment is the first day of the month following the date CalPERS receives the request. Exceptions may apply for certain contracting agency survivors who do not receive a monthly survivor check. Your survivor will need to contact your former employer for additional information.

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