RESET FORM

Flexible Benefits Program Enrollment & Change Form Plan Year 2019 (Courts)

Instructions: After completion, please return this form, along with any required back-up documentation, to your agency/department's Benefits Representative.

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email: Benefits.ServiceRep@ventura.org
Intranet: http://myvcweb/index.php/benefits
Internet: www.ventura.org/benefits

Type of Enrollment

- ☐ New Enrollment
- ☐ Mid-Year Change Request (must also complete *Mid-Year Change Request Form*)
- ☐ Add Dependent/Date & Reason_____
- ☐ Cancel Dependent/Date & Reason_____
- ☐ Other_____

1. Employee Data (please print)

NAME (LAST, FIRST, M.I.)	EMPLOYEE ID NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (NUMBER & STREET)	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**GENDER (M/F)**	**HIRE DATE**
AGENCY/DEPARTMENT NAME	**BARGAINING UNIT**	**EMAIL ADDRESS**	

2. Medical Plan Coverage (pre-tax rates; see the last page of this form for your biweekly flexible credit amount)

- ☐ Ventura County Health Care Plan HMO (EE only = $401.93/biweek, EE+1 = $458.34/biweek, EE + 2 or more = $566.83/biweek)
- ☐ BlueShield HMO Trio (EE only = $417.60/biweek, EE+1 = $502.29/biweek, EE + 2 or more = $601.55/biweek)
- ☐ BlueShield HMO Access+ (EE only = $481.80/biweek, EE+1 = $578.26/biweek, EE + 2 or more = $691.30/biweek)
- ☐ BlueShield High-Deductible PPO (EE only = $337.51/biweek, EE+1 = $408.70/biweek, EE + 2 or more = $493.53/biweek)
- ☐ Medical Plan Opt Out - must submit Opt Out Certification Form with proof of eligibility ($282.73/biweek)

3. Dental Plan Coverage (pre-tax)

- ☐ MetLife Dental PPO (EE only = $20.46/biweek, EE + 1 = $38.99/biweek, EE + 2 or more = $58.97/biweek)

4. Vision Plan Coverage (pre-tax)

- ☐ MES Vision (EE only = $2.03/biweek, EE+1 = $3.66/biweek, EE + 2 or more = $5.24/biweek)

5. Flexible Spending Accounts (pre-tax) – *JUDGES ONLY*

Health Care Account:

☐ I elect a Health Care Flexible Spending Account with a semi-monthly pledge of $_____ ($10.00 - $110.41/semi-monthly).
I understand that annual re-election is required.

Dependent Care Account:

☐ I elect a Dependent Care Flexible Spending Account with a semi-monthly pledge of $_____ ($10.00 - $208.33/semi-monthly).
I understand that annual re-election is required.

6. Employee/Dependent Information (If enrolling in an HMO medical plan, please be sure to designate a primary care physician for yourself and your dependents. You may add additional dependents on a separate sheet of paper. Also, you must attach documentation that supports the relationship for each dependent; required documentation is listed on the following page.)

NAME (LAST, FIRST, M.I.)	RELATION-SHIP	DATE OF BIRTH	GENDER (M/F)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	PHYSICAN NAME (HMO only)	Previously seen?
Employee	**Self**	**See Page 1**			☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐

7. Signature

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I also understand and agree that:

- I received a copy of the Flexible Benefits Program Benefit Plans Handbook, and I have read descriptions of benefits plans in which I am enrolling.
- My coverage elections on this form cannot be revoked or modified until the next open enrollment period, unless I have a qualifying change in status as defined by the IRS (see Benefit Plans Handbook, Chapter 1).
- I will verify that the enrollments and deductions I have authorized on this form have been implemented by reviewing my paystub for accuracy during the first pay period my selections are effective. I agree that failure to report an error within 30 days of the error's first appearance on my biweekly paystub is an affirmative election of the benefits listed on the paystub.
- I will notify the County immediately if I and/or my dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments.
- My pre-tax pay will be reduced by the amount of any required contributions noted for the coverage(s) elected after my flexible credits have been applied (flexible credit amounts are listed on page 3 of this form). My unspent flexible credits will be taxed and added to my paycheck as "Cash Back."
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I am enrolling.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s).
- A photocopy of this form is as valid as the original.
- If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.

✓

Signature **Date**

WAIVER OF PARTICIPATION IN THE FLEXIBLE BENEFITS PROGRAM *(NOT THE SAME AS OPTING OUT OF MEDICAL COVERAGE; DO NOT SIGN IF YOU WISH TO OPT OUT)*

If you are eligible to participate in the Flexible Benefits Program but DO NOT WANT TO ENROLL, read this WAIVER OF BENEFITS and sign and date where indicated:

WAIVER OF BENEFITS: I have been informed about the County's Flexible Benefits Program. I understand that, if eligible, I am entitled to a Flexible Credit Allowance each pay period if I am enrolled in the Ventura County Flexible Benefits Program. I choose not to enroll and thereby waive and forfeit the County Flexible Credit Allowance. I understand that this decision is binding and that I will not have another opportunity to enroll until the next annual Flexible Benefits Program open enrollment period.

Signature ***(DO NOT SIGN HERE IF YOU ARE ELECTING A PLAN OR OPTING OUT OF MEDICAL COVERAGE. THIS IS FOR WAIVERS ONLY.)*** Date

FOR OFFICE USE ONLY			
Department Authorization (Sign & Date)	HR/Benefits Authorization (Sign & Date)	Effective Date	Medical Plan Group ID #

☐ LTD Cert. Sent ☐ Life Ins. Cert. Sent ☐ COBRA Rights Sent (new spouse)

PY 2019

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
SPOUSE Your current legal husband or wife	• Copy of page 1 of your most-recently filed federal tax return (as filed) listing spouse (financial data may be blacked out), OR • Copy of official marriage certificate
REGISTERED DOMESTIC PARTNER Your domestic partner who is registered with you through the State of California or any other California County or Municipality's domestic partner registry	• Copy of Declaration of Domestic Partnership (as filed with the official domestic partner registry), AND • Proof relationship is still current (a household bill or account statement with your registered domestic partner's name on it that is mailed to your home on a regular basis and dated within the past 60 days.)
CHILD* under the age of 26 Your child under the age of 26 (certain unmarried children, if handicapped prior to age 19 and continuously covered by a County-sponsored medical plan since prior to age 19, and incapable of self-support may be eligible beyond age 26, if proper documentation of disability is submitted)	One of the following: • Copy of page 1 of your most-recently filed federal tax return (as filed) listing child as dependent , OR • Copy of birth/adoption certificate, Qualified Medical Child Support Order, or court order of legal guardianship AND • Current residence and mailing address, if different than employee

* The basic definition of "child" is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse or registered domestic partner, or both.

Most birth certificates and marriage certificates can be ordered online at www.vitalchek.com, if you don't already have a copy. For copies of court documents such as adoption or guardianship proceedings, you can contact the Clerk of Court's office where the proceedings took place. Any costs you may incur to obtain your documents will be at your expense.

If you are unable to obtain any of the required documents, please contact County Benefits *as soon as possible* to determine if there are acceptable alternatives.

Biweekly Flexible Credits

Full-Time (regularly scheduled to work at least 60 hours per pay period)
Courts SEIU = $460.00/biweek
Courts MGMT Category M1 & M2 = $650.00/biweek
Courts MGMT Category M3 = $625.00/biweek
Courts MGMT Category M4 & M5 = $600.00/biweek

Part-Time (regularly scheduled to work 40-59 hours per pay period)
Courts SEIU = $410.00/biweek
Courts MGMT = $530.00/biweek