CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

You must submit a completed enrollment form and any required documentation to the DHRM Risk and Benefits Division within 60 days of your initial benefits eligibility date or qualified life event.

1. APPLICATION TYPE

☐ New Hire ☐ Rehire/Reinstatement ☐ Birth/Adoption ☐ Marriage/Domestic Partnership ☐ Open Enrollment

☐ Loss of Coverage ☐ Divorce or Termination of Domestic Partnership ☐ Other -Please explain: _____

2. YOUR PERSONAL INFORMATION

Last Name	First Name	Middle Initial

Street Address (cannot be a P.O. Box)	Apt. #	City	State	Zip

Employee ID#	Birth Date	Phone Number

3. EMPLOYMENT INFORMATION

Department Name	Rep Unit	FT ☐	PPT ☐	Sworn ☐

4. HEALTH PLAN ELECTION

☐ Kaiser
☐ Anthem Select HMO
☐ Anthem Traditional HMO
☐ Health Net SmartCare
☐ Blue Shield Access
☐ Blue Shield EPO
☐ Blue Shield Trio
☐ Western Health Advantage
☐ United Healthcare
☐ United HealthCare Harmony
☐ PERS Gold PPO
☐ PERS Platinum PPO
☐ PORAC (Sworn Police only)
☐ Waive Medical Coverage (OPOA are not eligible)
☐ Medical Waiver Plan-Cash In Lieu Medical Waiver Cash Plan form and proof of coverage required. OPOA are not eligible.

Primary Care Physician _____ Physician ID# _____

Plan availability is based on your home zip code (in the City's system) or work zip code. Verify plan availability using CalPERS Medical Plan Zip Code Search tool.

☐ Check box to use work zip code ☐ If recently covered with CalPERS medical from another agency, enter coverage end date _____

5. DENTAL & VISION PLAN ELECTION *FOR NON-SWORN & UNREPRESENTED EMPLOYEES

☐ Delta Dental PPO*
☐ DeltaCare USA HMO*
☐ WAIVE DENTAL
☐ Sworn Police OPOA Dental
IAFF Sworn Fire - Submit Firefighter Dental Enrollment Form (click link to access form)
☐ Vision Service Plan*
☐ Waive Vision Coverage

6. DEPENDENTS COMPLETE SECTION BELOW TO ADD OR DROP DEPENDENTS

You must submit required eligibility documentation and provide SSN for all dependent enrollments. See page 2 for list of required documents.

Medical		Dental		Vision		Last Name	First Name	MI	Full SSN	Date of Birth	Relationship
Add	Drop	Add	Drop	Add	Drop						
Add	Drop	Add	Drop	Add	Drop						
Add	Drop	Add	Drop	Add	Drop						
Add	Drop	Add	Drop	Add	Drop						
Add	Drop	Add	Drop	Add	Drop						

7. LIFE INSURANCE BENEFICIARY DESIGNATION *(NON-SWORN & UNREPRESENTED EMPLOYEES)*

I appoint as revocable beneficiary(ies) of insurance payable in the event of my death:

	Name	Relationship	Address	Benefit %
Primary Beneficiary(ies)				
Contingent Beneficiary(ies) (Contingent beneficiaries are in the event of death of all primary beneficiaries)				

I certify that information on this document is true and correct and I give the person(s) administering the plans in which I enroll and/or their agents permission to verify any and all information. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plans and the City of Oakland for any benefits paid for me and/or my dependents if I or my dependents subsequently prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the falsification of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form.

Your Signature: _____ Date: _____

PERS ENTRY: ORACLE ENTRY: EFECTIVE DATE:

PLEASE SEE PAGE 2 OF THIS FORM FOR ADDITIONAL INFORMATION

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

- Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:
- The City of Oakland **DHRM – Risk & Benefits Division** will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- **You agree to submit any contribution required on your part directly to the** City of Oakland **DHRM – Risk & Benefits Division during any unpaid leave of absence.**
- Your participation in the City of Oakland sponsored benefits is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the City of Oakland) as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during the Plan year (January 1-December 31) unless you have a qualifying family status change.
- Coverage may be canceled at anytime. If you elect to waive/cancel your City of Oakland sponsored medical, dental or vision coverage, you may re-enroll only during an Open Enrollment period, if you've experienced a recent (within 60 days) loss of other coverage, or be assessed a 90-day waiting period.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to disciplinary action, dismissal and/or legal action.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the City of Oakland, you will promptly notify the City of Oakland **DHRM – Risk & Benefits Division** and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by the City of Oakland.
- If you elect to waive medical coverage, you must complete a Cafeteria / Medical Waiver Plan Form in addition to this form. Participation in the Waiver Program applies to an entire plan year. If participation in the Waiver program ends during the plan year and I again become eligible for the Cafeteria Plan within the same year, you must wait until the next plan year.
- The following documentation is required, in addition to a completed Employee Benefits Record Form, for any eligible individual's enrollment:

REQUIRED ELIGIBILITY DOCUMENTATION

The following supporting documents must be submitted with the Employee Benefit Record form to add dependent coverage, add coverage due to loss of other coverage, or enroll in the Medical Waiver Plan (Cash-In-Lieu).

	Required Documentation (click links to access forms)
Spouse	Marriage Certificate
Registered Domestic Partner	Domestic Partner Certification Domestic Partner Imputed Income Declaration Form
Natural Child	Birth Certificate
Domestic Partner Child	Domestic Partner Certificate and Child's Birth Certificate
Adopted Child	Adoption Papers
Stepchild	Birth Certificate (showing spouse as parent)
Child Legal Guardianship	Court Order CalPERS Affidavit Parent-Child Relationship Form First Page of Previous Year's Tax Return
Economically Dependent Child	CalPERS Affidavit of Parent-Child Relationship Form First Page of Previous Year's Tax Return
Disabled Child	CalPERS Questionnaire & Medical Report For Disabled Dependent Form CalPERS Authorization to Disclose Health Information Form
Court Order Child	Court Order
Loss of Coverage	Proof of Loss of Coverage
Medical Waiver Plan – Cash In Lieu	Medical Waiver Plan Election Form Proof of Other Medical Coverage

REQUIRED DOCUMENTS TO CANCEL BENEFITS FOR SPOUSE/DOMESTIC PARTNER DUE TO DISSOLUTION OF MARRIAGE OR DOMESTIC PARTNERSHIP

	Required Documentation
Spouse	Copy of Divorce Decree
Domestic Partner	Copy of Termination of Domestic Partnership document

Where to Submit Forms:

- **FAX:** **(510) 238-6560**
- **Email:** **BenefitsAdmin@oaklandca.gov**
- **Drop off:** **City of Oakland Benefits Unit**
  150 Frank H. Ogawa Plaza, 2nd Floor HR Desk
  Oakland, CA 94612