CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

You must submit a completed enrollment form and any required documentation to the DHRM-Risk & Benefits Division within 60 days of your initial benefits eligibility date or within 60 days of a qualified change in family status.

APPLICATION TYPE

☐ New Hire ☐ Rehire / Reinstatement ☐ Birth / Adoption ☐ Marriage / New Domestic Partnership / Divorce ☐ Open Enrollment
☐ Loss of Coverage ☐ Other-Please explain: _____

YOUR PERSONAL INFORMATION

Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip

Last four of Social Security Number or Employee ID #	Birth Date	Phone Number	Gender
			☐ Male ☐ Female

EMPLOYMENT INFORMATION

Department Name	Job Class	Rep Unit	FT	PPT	Sworn
			☐	☐	☐

CHOOSE YOUR HEALTH PLAN

*You must live in a covered service area to enroll in these plans. Please refer to the CalPERS Health Benefit Summary publication to confirm service areas or visit http://www.calpers.ca.gov.

☐ Kaiser Permanente
☐ Anthem HMO Select
☐ Anthem HMO Traditional
☐ Blue Shield Access
☐ Western Health Advantage
☐ United Healthcare
☐ HealthNet SmartCare HMO*
☐ PERS Choice PPO**
☐ PERS Select PPO**
☐ PERS Care PPO**
☐ PORAC (Sworn Police)
☐ **Waive Medical Coverage** (OPOA are not eligible)

Designate Physician:

Primary Care Physician _____ Physician ID# _____

** Administered by Anthem BlueCross

Ensure you verify your physician participates in the plan you selected

CHOOSE YOUR DENTAL PLAN NON-SWORN ONLY *

☐ Delta Dental*
☐ Delta Care USA *
☐ Sworn Police OPOA Dental
☐ IAFF Sworn Fire (Indemnity Dental)
☐ **Waive Dental Coverage**

CHOOSE YOUR VISION PLAN NON-SWORN ONLY *

☐ Vision Service Plan*
☐ **Waive Vision Coverage**

TO ADD OR DROP DEPENDENTS FROM YOUR BENEFITS, PLEASE COMPLETE THE BELOW

You must submit required eligibility documentation for and provide SSN for enrollment of all dependents. See the reverse side of this form for details of required documentation..

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						

LIFE INSURANCE (*NON-SWORN EMPLOYEES ONLY*)

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

(Contingent beneficiaries are in the event if death of all primary beneficiaries)

Primary:

Name _____ Relationship _____ % of Benefit _____

Name _____ Relationship _____ % of Benefit _____

Contingent:

Name _____ Relationship _____ % of Benefit _____

Name _____ Relationship _____ % of Benefit _____

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:	PCP VERIFICATION DATE:

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR ADDITIONAL INFORMATION

CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

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

	EBR	Marriage Cert.	Domestic Partner Cert.	Non-Tax Of Benefits	Birth Cert.	Adoption Cert.	Court Order	Tax Returns	Medical Evidence	PERS Affidavit
Employee	▪									
Spouse	▪	▪								
Domestic Partner	▪		▪	▪						
Natural Child	▪				▪					
Step Child	▪	▪			▪					
Domestic Partner Child	▪		▪		▪					
Adopted Child	▪					▪				
Child Legal Guardianship	▪						▪			
Economically Dependent Child	▪				▪			▪		▪
Disabled Child	▪								▪	
Court Order Child	▪						▪			

REQUIRED DOUCUMENTS TO CANCEL BENEFITS FOR SPOUSE/DOMESTIC PARTNER

	EBR	Dissolution of Marriage Certificate	Dissolution Domestic Partner Certificate
Employee	▪		
Spouse	▪	▪	
Domestic Partner	▪		▪