City of San Clemente
Health Plan Enrollment Form
For Medical, Dental, and Vision Coverage

If you are making a change due to a life event (marriage, birth, divorce, loss of coverage, etc.) additional documentation must be presented to Human Resources in order to process the change. Please contact Melissa Barber at 361-8353 for more information. Also, please note that if you're adding dependents outside of open enrollment, you have 60 days from the event date (birth, marriage, loss of coverage, etc.) to add them to your plan. After 60 days, they will be subject to a 90-day waiting period for benefits beginning the date HR receives your completed forms.

IMPORTANT NOTE: If you are adding a spouse or domestic partner to your coverage, you will need to bring a copy of your marriage certificate or certificate of domestic partnership to HR when you turn in your enrollment forms (regardless of when you were married or the domestic partnership was established). For dependent children who will be added, you must bring copies of their birth certificates when you turn in your enrollment forms.

EMPLOYEE INFORMATION

Name:	**Date of Birth:** _____/_____/_____
Social Security #: _____ - _____- _____	**Gender:** ☐ Male ☐ Female **Married:** ☐ Yes ☐ No
Address: _____ _____ City State Zip	**Phone Number:** ( ) _____ - _____ **Email:** _____

Type of Action:

- ☐ **NEW Enrollment** (Not currently enrolled)
- ☐ **CHANGE in Enrollment** (You are enrolled and are):
  - ☐ Changing health plans (when authorized)
  - ☐ Adding or deleting dependents
- ☐ **OPT OUT of Medical Coverage** (You will need to provide documentation that you are covered under another insurance plan to opt out or cancel medical coverage)
- ☐ **OPT OUT of Medical and Dental Coverage** (You will need to provide documentation that you are covered under another insurance plan to opt out of medical coverage)
- ☐ **OPT OUT of Dental Coverage**

Coverage Tier: ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family

DEPENDENT INFORMATION
(List all dependents currently enrolled, and any to be added or deleted)

Last Name	First Name	MI	Social Security #	Male/ Female	Date of Birth	Relationship	Add/ Delete

CALPERS MEDICAL ENROLLMENT ELECTION

	MEDICAL PLAN	PLAN CODE (OC or LA Area)
☐	Anthem Blue Cross Select HMO	507 or 508
☐	Anthem Blue Cross Traditional HMO	510 or 511
☐	Blue Shield Access+ HMO	526 or 527
☐	Blue Shield Trio HMO	088 or 452
☐	Health Net Salud y Mas HMO	531 or 532
☐	Health Net SmartCare HMO	529 or 530
☐	Kaiser Permanente CA HMO	534 or 535
☐	PERS Gold PPO	614 or 615
☐	PERS Platinum PPO	602 or 603
☐	Sharp Performance Plus HMO (San Diego)	575
☐	United Healthcare Alliance HMO	577 or 578
☐	United Healthcare Harmony HMO	399 or 475

Important Note:

The HMO plans have coverage in specific areas, and certain plans may not offer coverage in your area.

Make sure the medical plan you choose is available in your area before you make your election.

DELTA DENTAL ENROLLMENT ELECTION

☐ Delta Dental Premier Plan
Plan #8793-0001

☐ Delta Care DHMO Plan
Plan #72012-00104

Primary Care Dentist ID #: DC_____

(Make sure your dentist is covered under the plan you want and they are accepting new patients. If you do not designate a Primary Care Dentist, the plan will select one for you).

☐ OPT OUT of Dental Coverage

VSP VISION ENROLLMENT ELECTION

☐ VSP (Vision Service Plan) Plan #30005394-0001

I elect to ENROLL IN (OR MAKE A CHANGE TO) the Health Benefits Plans as shown on this form, and I authorize deductions to be made 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 also certify that the names of all dependents listed on this form are eligible dependents as defined under the City's plans.

_____ _____

Employee Signature Date

HR USE ONLY

Permitting Event:
- ☐ New Employee
- ☐ Open Enrollment: _____
- ☐ Life Change: _____
- ☐ Other: _____

Date Received by Human Resources:

Permitting Event Date:

Effective Date of Action:

_____ _____ _____

Signature of Health Benefits Officer Print Name Date