



BENEFITS ENROLLMENT GUIDE FOR NEW HIRES

2014

These instructions will help you navigate through the enrollment process in making your benefit elections as a new employee.



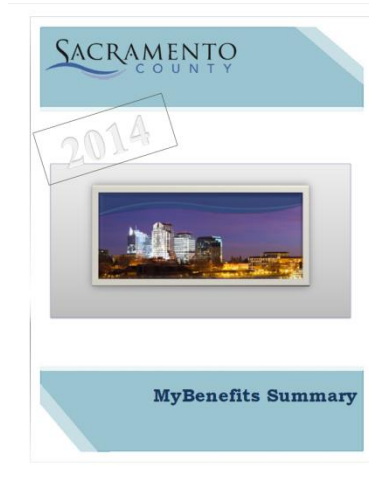
RESOURCES

If you have additional benefits questions you can access the following resources:

WEBSITE

<http://www.personnel.saccounty.net/Benefits/Pages/default.aspx>

MYBENEFITS SUMMARY



BENEFITS OFFICE STAFF

The Benefits Office staff can be reached Monday through Friday, 8am to 5pm

700 H Street, Suite 4667, Sacramento, CA 95814

<http://personnel.saccounty.net/benefits.htm>

(916) 874-2020 Phone Email: MyBenefits@saccounty.net

(916) 874-4621 Fax Mail Code: 09-4667

IMPORTANT INFORMATION

COVERAGE TAKES EFFECT THE FIRST DAY OF THE MONTH FOLLOWING YOUR COMPLETED ENROLLMENT

- **New employees must enroll in benefits within the first 30 days of hire or rehire**

If you do not enroll within the first 30 days of hire, you will be default enrolled into the Kaiser High Deductible and Delta Dental single coverage plans, and Basic life insurance coverage. You will not be able to make changes to your coverage until Open Enrollment, or within 30 days of notifying our office of a qualifying event—this includes changing your medical plan, enrolling dependents, and adding vision coverage.

- **If you are enrolling dependents to any coverage OR waiving your medical plan, the enrollment process is two steps**

STEP 1. You must first complete the online enrollment, and

STEP 2. You must submit dependent documentation within 7 days of completing your online enrollment. Documentation for dependents must show legal relation to you:

SPOUSE-Marriage Certificate	DOMESTIC PARTNER-State Registration
CHILD-Birth Certificate	CHILD'S LEGAL GUARDIAN-Court Order
STEPCHILD-Childs birth cert and marriage cert to child's parent	
WAIVING MEDICAL-Proof of enrollment in another group plan	

If you are not able to obtain the required documentation you **MUST** contact our office before the deadline to request an extension. Documents can be hand delivered, faxed, emailed, or mailed to our office.

SUBMIT DOCUMENTS TO:		
700 H Street, Room 4650, Sacramento CA 95814		
916.874.4621 Fax	09-4650 Mail Code	MyBenefits@saccounty.net

- **If the online system does not recognize you and will not allow you to enroll it is most likely a timing issue**

Not to worry, this is common for employees hired later in the month. BenefitBridge loads new hires once a week, usually on Friday afternoon. If you are unable to enroll, you should complete the paper enrollment form and submit it to our office as a placeholder for coverage. Then check back Friday afternoon to complete your online enrollment. The paper form can be found on the Documents and Forms section of the Benefits Office website at:

<http://www.personnel.saccounty.net/Benefits/Pages/Documents.aspx>

NEW USER REGISTRATION

If you have not used BenefitBridge previously, you need to register before you can enroll. If you already have a username and password, you can skip the registration process.

Go to **www.benefitbridge.com/saccounty**

Click on “Register”

STEP 1

- Enter your first and last name—Exactly as they appear on your master file
- Type the last four digits of your social security number
- Enter the 6 digit code in the shaded box on your screen
- Click on “Register”

The screenshot shows the 'Register' page for the County of Sacramento Active Employees. It includes a header with the county logo and 'Welcome to BenefitBridge'. The main content area is titled 'Register' and shows 'Step 1' as the current step. Instructions for Step 1 state: 'To view your personal benefits information you will need to create an account using your first and last names as they appear on your payroll statement. Once you have entered the information below, click Register. (If your names do not match, you will receive registration "tips" as well as BenefitBridge Support contact information.) Names and 6-Digit Code fields are NOT case sensitive.' Below the instructions are three input fields: 'First Name', 'Last Name', and 'Last 4 Digits of Social Security Number'. There is also a shaded box for a '6-Digit Code' with a small image of a document next to it. A 'Register' button and a 'Return to Login Page' link are at the bottom.

STEP 2

- Create a username
- Create a password (must be at least 8 characters and include one number)
- Verify the password
- Enter your email address
- Click Save

The screenshot shows the 'Register' page for the County of Sacramento Active Employees, Step 2. It includes a header with the county logo and 'Welcome to BenefitBridge'. The main content area is titled 'Register' and shows 'Step 2' as the current step. Instructions for Step 2 state: 'Create a username and password. If your BenefitBridge record includes an email address, the Username and Email address fields will auto-fill with this information. If the Username field is "blank" you will need to create one. (You may change your email address if desired.) We will keep your email and personal information private.' Below the instructions are four input fields: 'Username', 'Password', 'Verify password', and 'Email address'. A 'Save' button and a 'Return to Login Page' link are at the bottom.

STEP 3

Congratulations, you have successfully registered!
Your username and password should be displayed

- Keep them for future use

The screenshot shows the 'BenefitBridge' registration page, Step 3. It includes a header with the 'BenefitBridge' logo and 'Welcome to BenefitBridge'. The main content area is titled 'Register' and shows 'Step 3' as the current step. Instructions for Step 3 state: 'Congratulations! You have successfully completed the online registration for BenefitBridge. Your username and password are displayed below. (Please keep this information in a safe place.) Going forward, you will log in to BenefitBridge as a RETURNING USER. Welcome to BenefitBridge!' Below the instructions are two input fields: 'Username' and 'Password'. 'Continue' and 'Print View' buttons are at the bottom.

ENROLLING IN BENEFITS

After you register you are ready to begin the online part of the enrollment process.

If you are enrolling dependents to any coverage or you are waiving your medical coverage, remember, the enrollment process is two steps—**you must also submit documentation**.

Click “Begin Life Event Enrollment”

The screenshot shows the County of Sacramento Active Employees Benefits Administration website. The header includes the County of Sacramento logo and the text "COUNTY OF SACRAMENTO Active Employees". Below the header is a navigation bar with links: Administration, Home, Benefits, Enrollment, Health Care Reform, Health & Wellness, Resources, and Retirement. A secondary navigation bar includes links: Admin Home, Upload Forms, Contacts, Announcements, FAQs, and Briefings. The main content area is divided into several sections:

- Enrollment Center:** Contains links for Review Carrier Offerings, Review Current Benefits, Compare Plan Designs, and a circled button for **Begin Life Event Enrollment**.
- Administrative Links:** Contains links for Benefits Administration, Upload Forms, Update Contacts, and Update Announcements.
- External Links:** Contains links for Keenan Health Care Reform Website, California Department of Education, CalPERS, CalSTRS, Keenan COBRA, Medicare, and Social Security.
- BenefitBridge Support:** Contains contact information (BenefitBridge@Keenan.com, 800.814.1862, 8:00 am - 5:00 pm Monday-Friday) and guides/resources (Administrator Reference Guide, Recorded Video Lessons: Enrollments Tab, Enrollment Approval Process, Overview of BenefitBridge Reports).
- Benefits Administration:** Contains a link to access the Benefits Administration page.
- Announcements:** Contains a section for February 2014 Release - Report Enhancement, including New Social Security Number Display Options on the Carrier Billing Report (No - Remove SSN, Mask - Display last four digits of SSN, Full - Display full SSN). It also includes Password Requirements - Updated January 2014, stating that BenefitBridge password requirements have been updated and listing the new requirements (Must be 8 - 16 characters in length, Must contain at least one character from each of the following four categories: Uppercase letter, Lowercase letter, Number (0 - 9), Non-Alphanumeric character (e.g., @, #, %), Expires every 90 days (users will be prompted to create new password), May not reuse any of the previous 9 passwords).

ENROLLING IN BENEFITS

- From the dropdown select **New Hire**. You should select New Hire if you are a rehire.
- Enter the date you were hired in the **Event Date** field, or the date you went to permanent status.
- You can enter notes in the comments section also.
- Click **Submit**

Life Events Changes Form

* Life Events Reason:

- Please Select...
- Deceased
- Ineligible Dependent
- Birth / Adoption
- Dependent Loss of Coverage
- Dependent Permanently Disabled
- Marriage
- Domestic Partnership
- Spouse Gains/Loses Coverage
- Student Status
- New Hire**
- Other
- IRS Dependent Status
- Promotion
- Retiree - District Pav Ends

* Event Date:

mm/dd/yyyy

There are 5 tabs in the enrollment process—**Personal**, **Dependents**, **Core**, **Optional**, and **Review**. Your enrollment is not complete until you get to the Review tab at the end of your enrollment and check the “I agree” box and click submit.

Personal Dependents Core Optional Review

PERSONAL TAB

A summary of your personal information will be displayed, if it is accurate, click **Next Step**.

NOTE: THE EMAIL ADDRESS YOU ENTER HERE WILL BE THE ADDRESS USED TO NOTIFY YOU IF YOUR ENROLLMENT IS APPROVED. You will not receive any other notification. Please be sure the address is accurate if you would like to be notified of the status of your enrollment.

Personal

Dependents

Core

Optional

Review

Next Step >>

My Personal Info

Make Changes

- To enter an email address or phone number, click "Make Changes."
- If the information is correct, Click "Next Step."
- To update any other information, please contact your Human Resources Team representative.

TEST USER	Gender:	FEMALE
123 MAIN STREET	Birth Date:	1/1/1960
TORRANCE, CA 90501	SSN:	***_**_****
	Phone:	(555) 555-5555
	Email:	HOMEEMAIL@EMAIL.COM
	Age:	50

- If you need to make changes to your phone number or email address, click on the **Make Changes** button, make the changes and click **Save Changes**.
- For name and address changes, you must contact your Department of Personnel Services Service Team representative.
- Once you are satisfied with Personal details, click **Next Step**.

DEPENDENTS TAB

You should list any eligible dependent that will be enrolled in coverage here. If the dependent(s) listed are the dependents you are enrolling, or you are not enrolling dependents click **OK, continue to Core coverage.**

IMPORTANT:

Adding a dependent to this screen **DOES NOT** enroll them in any coverage. Dependents are enrolled to coverage on the Core tab.

DEPENDENT	SSN	RELATION	AGE	STUDENT	DISABLED	ADDRESS	OPTIONS
SPOUSE . USER	****_**-3333	SPOUSE	48	NO	NO	SAME	Edit Dependent Remove Dependent
CHILD . USER	****_**-0000	CHILD	1	NO	NO	SAME	Edit Dependent Remove Dependent

- **IF YOU NEED TO ADD A DEPENDENT:**

Click [Add a Dependent](#) and enter the required dependent information-- repeat for each family member (SSN is required, and be sure to submit dependent documentation to the Benefits Office). When you are finished with dependents, click **OK, continue to Core coverage.**

- **IF YOU NEED TO EDIT EXISTING DEPENDENTS:**

Click [Edit Dependent](#), make the changes, click [Save Changes](#), then [Back to All Dependents](#)

CORE TAB

This is where you choose your plans and add dependents to coverage. The left column shows the Coverage Type--you select your options for **MEDICAL, DENTAL, OPTIONAL LIFE INSURANCE AND HEALTH SAVINGS ACCOUNT** on this screen. Select **Enroll** next to each coverage type to begin. (Your screen will look slightly different)

Personal
Dependents
Core
Optional
Review

Ok, continue to Optional coverage >>>

My Core Coverage: Current & Upcoming

View / Change Tier

Review the coverage and/or dependents listed in Upcoming Election. This will be submitted to the Benefits Office for your enrollment.

If changes are required, click on the "Change" button next to the plan and follow the prompts.

If you would like to waive your medical benefit, please select the "Waive" button and follow prompts.









If you wish to view the plan details of your selection, click "Details."

If you make an error and wish to start over, click "Clear."

After you have made each election, you will be returned to this screen. Once you have completed elections for all of these benefits, you will be able to make your Optional Benefit elections.

If you are changing plans or waiving coverage as a mid-year life event, proof of the loss/gain of other group coverage is required within 7 days of your enrollment. Proof of other group coverage is required when waiving medical coverage during Open Enrollment.

Selected Upcoming Tier: ? BG01-NO CASH BACK 2014

COVERAGE TYPE	CURRENT ELECTION	UPCOMING ELECTION	EDIT COVERAGE				
1 Medical	 Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:	 Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee + One Plus Cost Per Pay Period: \$371.74 (24 deductions per year) Dependents Covered:	Change Waive Details Clear				
	<table> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> </tbody> </table>	Dependent	Relation	<table> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> </tbody> </table>	Dependent	Relation	
Dependent	Relation						
Dependent	Relation						
2 Dental	 Plan: Delta Dental-Active Coverage: Employee + One Plus Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:	 Plan: Delta Dental-Active Coverage: Employee + One Plus Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:	Change Details Clear				
	<table> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> </tbody> </table>	Dependent	Relation	<table> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> </tbody> </table>	Dependent	Relation	
Dependent	Relation						
Dependent	Relation						
Voluntary Term Life	 Plan: Optional Life-Option C Coverage: \$103,000.00 Cost Per Pay Period: \$18.75 (24 deductions per year)	 Plan: Optional Life-Option C Coverage: \$103,000.00 Cost Per Pay Period: \$29.41 (24 deductions per year)	Change Waive Details Clear				
3 Group Term Life	 Plan: Basic Life-\$18K Coverage: \$18,000.00 Cost Per Pay Period: \$0.00 (24 deductions per year)	 Plan: Basic Life-\$18K Coverage: \$18,000.00 Cost Per Pay Period: \$0.00 (24 deductions per year)	Change Details Clear				
Health Savings Account	None	Plan: HSA Kaiser Active Annual Contribution Amount: \$5,000.00 Contribution Per Pay Period: \$192.31 (26 deductions per year)	Change Waive Details Clear				

CORE TAB-Medical Coverage

After clicking Enroll, this screen will pop up if you have eligible dependents. If you do not have dependents skip this page.

The screenshot shows a web interface with a tabbed menu at the top: Personal, Dependents, Core (selected), Optional, and Review. Below the tabs is a header area with the title 'Select Dependents to Cover' and three buttons: '<< Back', 'Cancel', and 'Ok, Next >>'. Below the header is a list of instructions:

- Please select the dependents you would like enrolled in the medical plan. Enrollment is not automatic; you must check the box to cover them even if they are already enrolled.
- Failure to check the box will result in your dependent not being enrolled.
- If you are going to waive medical coverage do not select any dependents.

Below the instructions is a table with three columns: DEPENDENT NAME, RELATION, and DEPENDENTS TO COVER. The table contains two rows of data:

DEPENDENT NAME	RELATION	DEPENDENTS TO COVER
JUDY A. BELL	SPOUSE	<input checked="" type="checkbox"/> Cover JUDY
BABY BELL	CHILD	<input checked="" type="checkbox"/> Cover BABY

Check the box for dependents that should be enrolled to the medical plan. If the box is not checked the dependent will not be enrolled into this plan. Click **OK, Next** when you are finished.

Documentation is required for any dependent that is checked on this screen, even if you provided it previously.

You have independent enrollment options for dependents between medical, dental, and vision coverage.

CORE TAB-Medical Coverage







Choose the medical plan you wish to enroll in.

There are six plans to choose from, please be sure the one you select is what you intend to enroll in. Then click **OK, Next**.

Personal
Dependents
Core
Optional
Review

Select Options
<< Back
Cancel
Ok, Next >>

Choose the medical plan in which you would like to enroll.

PLAN OPTIONS	PLAN DOCS	NAME & DESCRIPTION	SELECT ONE
		<u>Kaiser Permanente \$1500/\$3000 High Deductible -Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,237.90 Cost per Pay Period: \$0.00 (24 deductions per year)	<input checked="" type="radio"/>
		<u>Kaiser Permanente Traditional \$15 Copay HMO -Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,570.38 Cost per Pay Period: \$157.04 (24 deductions per year)	<input type="radio"/>
		<u>Sutter Health Plus \$1500/\$3000 High Deductible HMO-Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,232.62 Cost per Pay Period: \$0.00 (24 deductions per year)	<input type="radio"/>
		<u>Sutter Health Plus Traditional \$15 Copay HMO Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,582.70 Cost per Pay Period: \$163.20 (24 deductions per year)	<input type="radio"/>
		<u>Western Health Advantage \$1500/\$3000 High Deductible HMO-Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,213.20 Cost per Pay Period: \$0.00 (24 deductions per year)	<input type="radio"/>
		<u>Western Health Advantage Traditional \$15 HMO-Tier B</u> Coverage: Employee + One Plus Monthly Premium: \$1,583.08 Cost per Pay Period: \$163.39 (24 deductions per year)	<input type="radio"/>

CORE TAB-Medical Coverage

If you have a primary care doctor that you or your dependents want assigned for your care you must enter the Provider ID in the spaces below. The Provider ID can be found by visiting the website for the plan you are enrolling and completing the doctor search:

SUTTER HEALTH <http://www.sutterhealthplus.org/providersearch>
WESTERN HEALTH <https://www.westernhealth.com/search-for-providers/>

Kaiser enrollees can skip this step; the Provider ID is not required.

Personal Dependents Core Optional Review

Enter Coverage Details ?

<< Back Cancel Save PCP and Continue >>

Sutter Health Plus Sutter Health Plus \$15 HMO 2

VERY IMPORTANT – PLEASE READ CAREFULLY!

- The plan you have selected requires that you and/or your dependents have a Primary Care Physician (PCP). If you would like to select your physician, you must provide their provider ID number. The links below will take you to the carrier's website where you can locate your physician's Provider ID.

You and your dependents can select different Primary Care Physicians.

If you do not provide the Provider ID number for the physician, you will be assigned one by your carrier.

If you are already enrolled in this plan and are not changing providers, you do not have to add your Provider ID, the carrier has it on file.

FIRST NAME	RELATION	PROVIDER ID	EXISTING PROVIDER
THOMAS	Subscriber	<input type="text"/>	<input type="checkbox"/>
JUDY	SPOUSE	<input type="text"/>	<input type="checkbox"/>
BABY	CHILD	<input type="text"/>	<input type="checkbox"/>

If you do not enter a Provider ID or if it is entered incorrectly you will be assigned to a Primary Care doctor by your health plan. The doctor information will be on the ID card you receive in the mail. You can change your PCP anytime by contacting your health plan carrier directly.

CORE TAB-Dental Coverage

You will be returned to this screen to complete the same steps for the dental plan.

Personal

Dependents

Core

Optional

Review

Ok, continue to Optional coverage >>>

My Core Coverage: Current & Upcoming

View / Change Tier

Review the coverage and/or dependents listed in Upcoming Election. This will be submitted to the Benefits Office for your enrollment.

If changes are required, click on the "Change" button next to the plan and follow the prompts.

If you would like to waive your medical benefit, please select the "Waive" button and follow prompts.





If you wish to view the plan details of your selection, click "Details."

If you make an error and wish to start over, click "Clear."

After you have made each election, you will be returned to this screen. Once you have completed elections for all of these benefits, you will be able to make your Optional Benefit elections.

If you are changing plans or waiving coverage as a mid-year life event, proof of the loss/gain of other group coverage is required within 7 days of your enrollment. Proof of other group coverage is required when waiving medical coverage during Open Enrollment.

Selected Upcoming Tier: 2 BG01-NO CASH BACK 2014





COVERAGE TYPE	CURRENT ELECTION	UPCOMING ELECTION	EDIT COVERAGE				
1 Medical	<div>Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:</div>	<div>Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee + One Plus Cost Per Pay Period: \$371.74 (24 deductions per year) Dependents Covered:</div> <table><thead><tr><th>Dependent</th><th>Relation</th></tr></thead><tbody></tbody></table>	Dependent	Relation	<div>Change</div> <div>Waive</div> <div>Details</div> <div>Clear</div>		
Dependent	Relation						
2 Dental	<div>Plan: Delta Dental-Active Coverage: Employee + One Plus Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:</div> <table><thead><tr><th>Dependent</th><th>Relation</th></tr></thead><tbody></tbody></table>	Dependent	Relation	<div>Plan: Delta Dental-Active Coverage: Employee + One Plus Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:</div> <table><thead><tr><th>Dependent</th><th>Relation</th></tr></thead><tbody></tbody></table>	Dependent	Relation	<div>Change</div> <div>Details</div> <div>Clear</div>
Dependent	Relation						
Dependent	Relation						

After you select your dependents for dental coverage you will again be returned to this screen to make your selections for life insurance.

CORE TAB-Life Insurance

After you complete your selections for medical and dental coverage you can select your life insurance options. In addition to the Basic coverage provided by the County you can purchase additional coverage under the **Voluntary Term Life**. Click the **Enroll** or **Change** button then select the option the see the coverage and pay period cost.

Select **Waive** if you only want Basic coverage.

Voluntary Term Life	 Plan: Optional Life-Option C Coverage: \$103,000.00 Cost Per Pay Period: \$18.75 (24 deductions per year)	 Plan: Optional Life-Option C Coverage: \$103,000.00 Cost Per Pay Period: \$29.41 (24 deductions per year)	Change Waive Details Clear
Group Term Life	 Plan: Basic Life-\$18K Coverage: \$18,000.00 Cost Per Pay Period: \$0.00 (24 deductions per year)	 Plan: Basic Life-\$18K Coverage: \$18,000.00 Cost Per Pay Period: \$0.00 (24 deductions per year)	Change Details Clear

You can select any option within 30 days of your hire without completing the health questionnaire. You can decrease coverage at any time. Once coverage takes effect, increases will require a health questionnaire.



[Personal](#) [Dependents](#) [Core](#) [Optional](#) [Review](#)






Select Options [<< Back](#) [Cancel](#) [Ok, Next >>](#)

Options available to you are shown in the "Plan Options."

- Option A - 1x annual salary up to \$50,000 (including your basic coverage)
- Option B - 1x annual salary up to \$500,000, plus your basic coverage
- Option C - 2x annual salary up to \$500,000, plus your basic coverage
- Option D - 3x annual salary up to \$500,000, plus your basic coverage
- Option E - 4x annual salary up to \$500,000, plus your basic coverage
- Decline Voluntary Life plan

If you do not want to purchase Optional Coverage, please push the "Cancel" button and select "Waive Plan" on the next screen. To increase coverage, please complete the forms below and fax to the Benefits Office at 916-874-4621.

 [Life Insurance Short form \(upgrades\).pdf](#)  [Life Insurance.pdf](#)

PLAN OPTIONS	PLAN DOCS	NAME & DESCRIPTION	SELECT ONE
		<u>Optional Life-Option A (with \$18K BL)</u>	<input type="radio"/>
		<u>Optional Life-Option B</u>	<input type="radio"/>
		<u>Optional Life-Option C</u>	<input type="radio"/>
		<u>Optional Life-Option D</u>	<input type="radio"/>
		<u>Optional Life-Option E</u>	<input type="radio"/>

CORE TAB-Life Insurance

BENEFICIARY DESIGNATION

Whether you are purchasing additional coverage or just keeping Basic coverage you should complete the beneficiary designation form for your life insurance. The form is posted on this screen as a PDF link called **Life Insurance**. Print this form and fax or email it to our office after completing the applicable information.

Personal Dependents **Core** Optional Review

Select Options

Options available to you are shown in the "Plan Options."

- Option A - 1x annual salary up to \$50,000 (including your basic coverage)
- Option B - 1x annual salary up to \$500,000, plus your basic coverage
- Option C - 2x annual salary up to \$500,000, plus your basic coverage
- Option D - 3x annual salary up to \$500,000, plus your basic coverage
- Option E - 4x annual salary up to \$500,000, plus your basic coverage
- Decline Voluntary Life plan

If you do not want to purchase Optional Coverage, please push the "Cancel" button and select "Waive F increase coverage, please complete the forms below and fax to the Benefits Office at 916-874-4621.

[Life Insurance Short form \(upgrades\).pdf](#) [Life Insurance.pdf](#)

Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager



County of Sacramento

LIFE INSURANCE CHANGE FORM

Name _____ SSN/PIN _____
Address _____ City _____ Zip _____
DOB _____ Date of Hire _____ Email _____

Check all that apply:

☐ Beneficiary Change ☐ Dependent Enrollment ☐ Increase Coverage* ☐ Decrease Optional Coverage ☐ Waive All Optional Coverage

*Prudentia's Short form is required in addition to this form for applications to increase coverage

☐ Option A (1X salary-\$50,000 Cap) Does not include Basic Life ☐ Option B (1X salary) Includes Basic Life ☐ Option C (2X Salary) Includes Basic Life ☐ Option D (3X Salary) Includes Basic Life ☐ Option E (4X Salary) Includes Basic Life

BENEFICIARY INFORMATION	NAME AND ADDRESS	Relationship	DOB	Percentage
				%
				%
				%
				%
Trustee for minor child:		Phone		

DEPENDENT ENROLLMENT (BARGAINING UNITS 005 & 008 ONLY)		DOB
Spouse/DP Name		
Child Name		
Child Name		
Child Name		
Child Name		

I authorize my employer to deduct from my wages the premium, if any, for the elected coverage. To the best of my knowledge and belief, the information I have provided on this form is correct. I understand my coverage begins on the effective date assigned, provided I am actively at work.

Employee Signature _____ Date _____

Reviewed By _____ Date _____

(Sample of form)

DEPENDENT LIFE INSURANCE

There is life insurance coverage available for your spouse and children.

- If your Basic coverage is \$18,000 or \$50,000 your dependents are automatically covered for \$2,000; no additional action is necessary.
- If your Basic coverage is \$15,000, you must take action and enroll your dependents for them to be covered. The enrollment cannot be completed online; it is done on the Life Insurance form (PDF link and sample of form above). You have 30 days from your hire date to enroll dependents for life insurance. There is a small tax for this coverage. If you do not enroll dependents in the first 30 days of hire, you can do so during Open Enrollment or within 30 days of a qualifying event.

There is not an option to purchase additional life insurance coverage for dependents.

CORE TAB-Health Savings Account (HSA)

If you enrolled in a High Deductible health plan (HDHP), you can enroll in a Health Savings Account (HSA). Generally the enrollment screen pops up upon enrolling in a HDHP with your HSA partner. If that did not occur, you can enroll here by clicking **ENROLL**.

Health
Savings
Account

None

None

Enroll

Select your HSA plan:

- If you chose Kaiser's HDHP, you must select HSA Kaiser Active AND complete the HSA Wells Fargo Enrollment form
- If you chose Sutter's HDHP, you must select HSA Sutter, no additional forms are needed
- If you chose WHA's HDHP, you must select HSA WHA AND complete the HSA HEQ Enrollment form

Forms are PDF Links and should be sent to the Benefits Office

Then click **OK NEXT**

The screenshot shows the 'Select Options' screen for HSA enrollment. At the top are tabs: Personal, Dependents, Core (selected), Optional, and Review. Below the tabs are buttons: '<< Back', 'Cancel', and 'Ok, Next >>'. The main text area contains instructions: 'If you are enrolling in an HSA for the first time, you must also complete the Wells Fargo enrollment attachment and submit it to the Employee Benefits Office. Deductions will be taken on a before-tax basis.' It then asks to 'Select the option that best describes the Medical plan you elected, your Individual or Family coverage and your age.' It also states: 'Participants in an HSA may not also participate in a Flexible Spending Account (FSA) for Medical Reimbursement. If you are changing from an FSA to an HSA during Open Enrollment, please note that you cannot start contributions to an HSA until April 1 unless the balance in your MRA is \$0 on December 31.' and 'If you wish to cancel for 2014, please click the "Cancel" button.' Below this, it says 'No enrollment form is required for Sutter US Bank HSA'. At the bottom, there are two PDF links: 'HSA Wells Fargo Enrollment.pdf' and 'HSA HEQ Enrollment Form.pdf'. Two arrows originate from the top of the page: one points to the 'HSA Wells Fargo Enrollment.pdf' link and the other points to the 'HSA HEQ Enrollment Form.pdf' link. Below the links is a table with four columns: PLAN OPTIONS, PLAN DOCS, NAME & DESCRIPTION, and SELECT ONE.

PLAN OPTIONS	PLAN DOCS	NAME & DESCRIPTION	SELECT ONE
		<u>HSA Kaiser Active</u>	<input type="radio"/>
		<u>HSA Sutter</u>	<input type="radio"/>
		<u>HSA WHA</u>	<input type="radio"/>

CORE TAB-Health Savings Account (HSA)

Once you have selected your HSA plan and printed any necessary forms. You now need to designate your contribution amount. The annual amount entered here will be divided by the number of pay periods remaining in the year and deducted from your paycheck pre-tax. You can change your HSA contribution amount anytime.

Designate Your Annual Contribution:

Be sure you are selecting the annual amount you qualify for; page 15 of the MyBenefits Summary provides the maximums allowed by the IRS.

The screenshot shows a web form titled "Enter Coverage Details" with tabs for Personal, Dependents, Core, Optional, and Review. The "Core" tab is selected. The form is for "County HSA WHA". It contains instructions: "Enter the amount you would like deducted for the plan year. Deductions are taken over 24 pay periods." and "The pay period amount shown may be different than the actual amount from your paycheck if you are making a mid year change." Below this, it says "Contribution Annual 0.00 to 7550.00" and has a text input field with a dollar sign icon.

You will then be returned to the CORE TAB where you should review the plans you have enrolled in and the dependents you are covering. If any of the information is not correct, this is your opportunity to make changes. If the information is accurate click **OK Continue to Optional Coverage**.

The screenshot shows the "My Core Coverage: Current & Upcoming" screen. It has tabs for Personal, Dependents, Core, Optional, and Review. The "Core" tab is selected. At the top right is a button "Ok, continue to Optional coverage >>>". Below the title is a "View / Change Tier" button. The main content area contains instructions: "Review the coverage and/or dependents listed in Upcoming Election. This will be submitted to the Benefits Office for your enrollment." and several other prompts about changes, waivers, and details. Below this is a section "Selected Upcoming Tier: BG01-NO CASH BACK 2014". It contains a table with two columns: "CURRENT ELECTION" and "UPCOMING ELECTION". The table has two rows: "Medical" and "Kaiser Permanente". The "Medical" row shows "Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active" and "Coverage: Employee + One Plus". The "Kaiser Permanente" row shows "Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active" and "Coverage: Employee + One Plus". Below the table are buttons for "Change", "Waive", "Details", and "Clear". At the bottom, there is a section "Dependents Covered:" with a table for "Dependent" and "Relation".

COVERAGE TYPE	CURRENT ELECTION	UPCOMING ELECTION	EDIT COVERAGE
1 Medical	Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee + One Plus Cost Per Pay Period: \$0.00 (24 deductions per year) Dependents Covered:	Plan: Kaiser Traditional \$15 Copay - Tier A-No Cash Back Active Coverage: Employee + One Plus Cost Per Pay Period: \$371.74 (24 deductions per year) Dependents Covered:	<button>Change</button> <button>Waive</button> <button>Details</button> <button>Clear</button>

Dependent	Relation
-----------	----------

OPTIONAL TAB

You can enroll in Flexible Spending Accounts or VSP for voluntary vision on the OPTIONAL TAB.

The screenshot shows the 'Optional' tab selected in a navigation bar with 'Personal', 'Dependents', 'Core', 'Optional', and 'Review'. A button 'Ok, Continue To Final Review >>' is at the top right. Below is a section titled 'My Optional Coverage: Current & Upcoming' with a note: 'These benefits are optional. If no changes are desired, click on "OK, Continue to Final Review."' and a link 'DCRA Contract.pdf'. A table follows with columns: 'COVERAGE TYPE', 'CURRENT ELECTION', 'UPCOMING ELECTION', and 'EDIT COVERAGE'. It lists 'Flexible Spending Account' and 'Voluntary Vision', both with 'None' in the election columns and an 'Enroll' button in the edit column.

COVERAGE TYPE	CURRENT ELECTION	UPCOMING ELECTION	EDIT COVERAGE
Flexible Spending Account	None	None	<input type="button" value="Enroll"/>
Voluntary Vision	None	None	<input type="button" value="Enroll"/>

FLEXIBLE SPENDING ACCOUNTS

Select the annual amounts for the Medical Reimbursement Account and/or the Dependent Care Reimbursement Account if enrolling in these programs, then click **OK Next**.

The screenshot shows the 'Optional' tab selected. The main heading is 'Enter Coverage Details' with buttons '<< Back', 'Cancel', and 'Ok, Next >>'. The title is 'Flex Plan Services County FSA 2014'. Instructions include: 'Enter the total amount you would like deducted for each plan for the calendar year.', 'When entering your desired amount, Please do not use a comma or dollar sign. (Example: 5000.00)', 'Participants in an FSA Medical Reimbursement account may not also participate in a Health Savings Account (HSA).', 'Please refer to the Summary of Benefits and Flexible Benefit Plan Summary for a description of the plan rules regarding when and how this money must be spent.', and 'The pay period amount shown may be different than the actual amount from your paycheck if you are making a mid-year change.' There are two input fields: 'Unreimbursed Medical Annual 0.00 to 2500.00' and 'Dependent Care Annual 0.00 to 5000.00', both preceded by a dollar sign.

Unreimbursed Medical
Annual 0.00 to 2500.00
\$

Dependent Care
Annual 0.00 to 5000.00
\$

OPTIONAL TAB-Vision Coverage

VISION SERVICE PLAN

If you have waived medical coverage or enrolled in a High Deductible medical plan, you do not have vision coverage. You can elect to purchase coverage by clicking **ENROLL**.

NOTE: If you have selected coverage in an HMO plan, DO NOT enroll in the voluntary vision plan, your HMO coverage already includes vision.

Personal Dependents Core **Optional** Review

Ok, Continue To Final Review >>



My Optional Coverage: Current & Upcoming

These benefits are optional. If no changes are desired, click on "OK, Continue to Final Review."

If you have selected medical coverage under an HMO plan, DO NOT enroll in the voluntary vision plan; your vision is already included with your HMO.

However, if you have waived medical coverage or enrolled in a High Deductible plan and want vision coverage, you must enroll for voluntary vision.

[FSA Dep Care Contract.pdf](#)

COVERAGE TYPE	CURRENT ELECTION	UPCOMING ELECTION	EDIT COVERAGE								
Flexible Spending Account	None	None	Enroll								
Voluntary Vision	 Plan: VSP-Voluntary Vision Active Coverage: Employee + One Plus Cost Per Pay Period: \$6.40 (24 deductions per year) Dependents Covered: <table border="1"> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> </tr> </tbody> </table>	Dependent	Relation			 Plan: VSP-Voluntary Vision Active Coverage: Employee + One Plus Cost Per Pay Period: \$6.40 (24 deductions per year) Dependents Covered: <table border="1"> <thead> <tr> <th>Dependent</th> <th>Relation</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> </tr> </tbody> </table>	Dependent	Relation			Change Details Clear
Dependent	Relation										
Dependent	Relation										

Check the box for any dependents you are enrolling in vision coverage. Click **OK NEXT**

Personal Dependents Core **Optional** Review

Select Dependents to Cover << Back Cancel Ok, Next >>

DEPENDENT NAME	RELATION	DEPENDENTS TO COVER
JAMES THOMAS	SPOUSE	<input checked="" type="checkbox"/> Cover JAMES
PATRIC R. GARCIA	CHILD	<input checked="" type="checkbox"/> Cover PATRIC
RAYNA L. YUSON	CHILD	<input checked="" type="checkbox"/> Cover RAYNA

If your vision coverage is correct click **OK Continue to Final Review**

REVIEW TAB

This is your final opportunity to review the selections you have made and ensure they are correct prior to submitting your elections. Scroll down to review your coverage's to confirm you have selected your desired choices for yourself and any dependents.

Carefully read the Approval Details. If the selections reflect the coverage you want, **Check the "I AGREE" box, and then click "OK, Submit for Coverage"**.

County of Sacramento-Active
Summary of Benefits Effective 01/01/2014

My Review & Final Approval

Ok, Submit For Coverage

My Digital Signature

Approval Details:

I understand that my benefit elections will take effect on the effective date as detailed in the "County of Sacramento Active Summary of Benefits" available online. I understand that my benefit elections will be in effect until the next Open Enrollment period, unless my family status changes (e.g., loss of coverage for me or my dependents, change in marital status, change in spouse's/domestic partner's employment status.) I understand that I must notify Department of Personnel Services' (DPS) Service Team, if I experience a qualifying event. I understand that I am entitled to a copy of the plan documents for the benefit plans. These documents are available on the Internet on the County of Sacramento Department of Personnel Services, Employee Benefits Office website. I understand that if I have added a dependent I must provide documentation indicating that dependents legal relationship to me (even if the dependent was previously enrolled) to the County of Sacramento Department of Personnel Services within 7 days of submitting this enrollment. Failure to submit the appropriate documentation will result in that dependent not being enrolled and coverage not taking effect. For more information, please refer to the Summary of Benefits on the County of Sacramento Department of Personnel Services, Employee Benefits Office website, or contact the DPS Service Team, DEDUCTION AUTHORIZATION: If applicable, I authorize the County of Sacramento to deduct from my paycheck the required premium contributions. TIER B: I understand this election (if applicable) is irrevocable and forfeits all entitlements to cash back and PSI. I have read and understood the provisions outlined in this acknowledgment and the Summary of Benefits. All information entered is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded and disciplinary action taken. I accept the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, benefit coverage, and all associated policies and procedures. I understand that the County is relying on the use of my user ID and password as evidence that I have personally made these benefit elections.

I have reviewed and approved the information below; my Benefits Selection, and the information related to it including the description of the benefit as well as my Employer's contributions to the premium payment.

I understand and agree that by clicking "I AGREE" I am making this benefit election and granting my employer the right to use this acceptance in place of my written signature.

Your Approval:

☐ I AGREE (Check to confirm your final approval.)

Remaining Steps

?

LIFE EVENT CHANGES
All benefit changes made during a life event require documentation to support the event and is due to the Benefits Office within 7 days of submitting your online elections. The event must have occurred within the last 30 days, and any dependents being added to your coverage must meet the eligibility guidelines as stated in the MyBenefits Summary.

OPEN ENROLLMENT CHANGES
If you are waiving coverage or adding dependents during Open Enrollment, additional documentation is required. Proof of other group coverage must be submitted if you are waiving your medical coverage, and documentation indicating your dependent's legal relationship to you is required for any dependent being added, even if they were previously enrolled. Documents are due 7 days from the last day of Open Enrollment.

SUBMITTING DOCUMENTATION
Documents can be faxed to (916) 874-4621 or emailed to MyBenefits@saccounty.net. Please write your employee ID number on each document. Documents not received by the deadline will result in your change not being approved.

Print a copy for your records and follow the next steps.....

NEXT STEPS

You have finished the online portion of enrolling, now what?

Additional documentation is required to complete the enrollment process if you:

- Enrolled dependents to any coverage
- Waived your medical plan
- Enrolled in the HSA for Kaiser or WHA High Deductible plans

If the above scenarios do not apply to you, you can skip this page. Examples of acceptable documents are listed below—

If you enrolled dependents:

SPOUSE-Marriage Certificate	DOMESTIC PARTNER-State Registration	ADOPTED CHILD-Adoption Papers
CHILD-Birth Certificate	CHILD’S LEGAL GUARDIAN-Court Order	DISABLED CHILD-Proof of Disability
STEP CHILD-Childs birth cert and marriage cert to child’s parent		FOSTER CHILD-Placement Agreement

If you waived medical coverage:

Proof of enrollment in another **group** plan--letter from insurance carrier or employer or HR office, medical card (Kaiser cards are not acceptable). Proof must indicate that you are covered, what the group is, and the effective date of coverage.

If you enrolled in the HSA for Kaiser or WHA high Deductible plans:

- Kaiser High Deductible-Addendum C -Wells Fargo Health Savings Account Authorization Form
- WHA High Deductible Plan- HSA Authorization Form for Health Equity

Addendum C
Wells Fargo Health Saving Account
Account Authorization Form

HSA Authorization Form HealthEquity
FOR GROUP HEALTH COVERAGE Building Health Savings™

You have 7 days from the date of your online enrollment to submit the documents, even if you are a rehire and submitted them previously. If you need additional time to obtain the required documentation you **MUST** contact our office before the deadline to request an extension. Documents can be hand delivered, faxed, emailed, or mailed to our office.

If we do not receive the documents by the deadline the impacted enrollment will be denied without further notice.

Employee Benefits Office		
700 H Street, Room 4650, Sacramento CA 95814		
916.874.4621 Fax	09-4650 Mail Code	MyBenefits@saccounty.net

NEXT STEPS

Once your documents have been received our staff will review them to determine if they meet eligibility standards. If you entered your email address on the PERSONAL TAB you will receive an auto email stating the coverage was approved. If you did not enter an email address, you will not receive notification.

When is my coverage effective?

Your coverage will take effect the first day of the month following your enrollment.
(Example; if you enroll on March 26, your coverage will begin on April 1st once it is approved)

If you have enrolled at the end of the month there may be a brief lag time before your information is updated with your carrier. Enrollments are sent electronically to the carriers on a weekly basis. If you have an emergency and cannot wait for the auto process, contact our office to be manually updated.

How do I access my coverage?

Once your coverage is updated, call the carrier to make an appointment.

MEDICAL-ID cards are mailed by the carrier directly to you. If you need to access care and do not have your ID card yet call your carrier and provide your Group number.

Plan Name	Group Number
Sutter HMO	001001-000001
Western HMO	107282-A000
Kaiser HMO	600644-0000

Plan Name	Group Number
Sutter High Ded	001001-100001
Western High Ded	107282-A000
Kaiser High Ded	600644-2001

DENTAL-Delta Dental does not mail cards. Give your SSN and the below group number.

Delta Dental of California	2476-0001
----------------------------	-----------

VISION-VSP does not mail cards. Give the provider your SSN and the group number.

Vision Service Plan (VSP)	30015915-0001
---------------------------	---------------

HEALTH SAVINGS ACCOUNT-If you signed up for an HSA you will get your debit card and packet in the mail from the vendor about 7-10 days after your enrollment is approved.

LIFE EVENT CHANGES

MAKING CHANGES TO COVERAGE AFTER INITIAL ENROLLMENT

Now that you have enrolled in benefits, the only time you can generally make changes to your coverage is during Open Enrollment or within 30 days of a life event. You have 30 days from the date of your event to change coverage.

EXAMPLES OF CHANGES REQUIRING A QUALIFYING EVENT

	<u>Change plans</u> -Kaiser to WHA, waiver to Sutter, WHA to waive, etc. (proof of group coverage is required to waive medical)
	<u>Change to Tier B</u> -This election is irrevocable once made
MEDICAL	<u>Add dependents</u> -Add spouse/DP and/or children (dependents must meet dependent eligibility requirements, dependent documentation is required)
	<u>Drop dependents</u> -Remove spouse and/or children from coverage (no documentation required)
DENTAL	<u>Add dependents</u> -Add spouse/DP and/or children (dependents must meet dependent eligibility requirements, dependent documentation is required)
	<u>Drop dependents</u> -Remove spouse and/or children (no documentation required)
FLEXIBLE SPENDING ACCOUNTS	Enroll/change election for Dependent Care Reimbursement Account
	Enroll/change election for Medical Reimbursement Account
DEPENDENT LIFE INSURANCE	Employees of UPE (BG 005 & 008) can enroll dependents for life coverage (action cannot be performed online; paper enrollment required). Coverage for dependents in all other units is automatic.

EXAMPLES OF CHANGES PERMITTED ANYTIME DURING THE YEAR

These changes can be made without a qualifying event; they may also be made during Open Enrollment

OPTIONAL LIFE INSURANCE	Increase coverage (subject to approval), decrease coverage, waive all optional life coverage, make beneficiary updates
HEALTH SAVINGS ACCOUNT	Enroll/Change annual election (must be enrolled in High Deductible Plan)
DEFERRED COMPENSATION	Enroll, increase contribution, decrease contribution, change investments, change beneficiary

CHANGES THAT ARE NEVER PERMITTED

These benefits are automatically provided by the County to all benefit eligible employees

EAP	Employee cannot waive EAP benefits
BASIC LIFE INSURANCE	Employee cannot waive the basic life benefit
DENTAL COVERAGE	Employee cannot waive dental coverage for self

LIFE EVENT CHANGES

This chart lists common events and is not an exhaustive list. If you believe you have experienced a qualifying event that is not listed here please contact the Benefits Office to determine if a change is permitted and what documentation is required.

EXAMPLES OF LIFE EVENTS

EVENT	CHANGES PERMITTED	DOCUMENTS REQUIRED
New Marriage or Domestic Partnership	Add dependents: <ul style="list-style-type: none"> Spouse or domestic partner Children of the spouse/partner Previously eligible children (if spouse/partner is added) 	<ul style="list-style-type: none"> Marriage certificate or domestic partner registration Birth certificate, paperwork from adoption, legal guardianship or foster placement of spouse/partner's newly added dependents Social Security Number for all being enrolled
	Change coverage: <ul style="list-style-type: none"> Change plans-only if you are adding spouse or domestic partner Waive coverage-only if gained new coverage 	<ul style="list-style-type: none"> Marriage certificate or domestic partner registration Must provide proof of other coverage
Divorce, Legal Separation, or termination of a Domestic Partnership	Remove dependents: <ul style="list-style-type: none"> Delete former spouse or domestic partner Must delete stepchildren or children of former partner 	<ul style="list-style-type: none"> Final judgment or domestic partnership termination Copy of legal separation document
	Change coverage: <ul style="list-style-type: none"> Enroll in plan-only if you lost other coverage 	<ul style="list-style-type: none"> Proof of loss of coverage
New baby; a child placed for adoption, legal guardianship, and/or a foster child	Add dependents: <ul style="list-style-type: none"> Newly eligible dependents Add previously eligible, but not enrolled dependents 	<ul style="list-style-type: none"> Birth certificate, paperwork from adoption, legal guardianship or foster placement Social Security number for all being enrolled <p>Note: if the Social Security Number is not available, enroll the child and provide the number as soon as it is available</p>
	Change Coverage: <ul style="list-style-type: none"> Change plans-only if you are adding new dependent 	<ul style="list-style-type: none"> Birth certificate, paperwork from adoption, legal guardianship or foster placement of dependent being added
Losing a dependent-child reaching age 26; end of a legal guardianship, foster relationship, or stepchildren when parent's divorce, domestic partnership termination, or separation	Remove dependent: <ul style="list-style-type: none"> Delete dependent 	<ul style="list-style-type: none"> Court provided proof of the change in the relationship
	Change coverage: <ul style="list-style-type: none"> Change plans-only if you are deleting dependent 	
Employee and/or dependents gaining other group coverage	Remove dependents: <ul style="list-style-type: none"> Delete dependent(s) that gain coverage 	<ul style="list-style-type: none"> Proof of other group coverage for each dependent being deleted
	Change coverage: <ul style="list-style-type: none"> Waive coverage Coverage option change 	<ul style="list-style-type: none"> Proof of other coverage

Employee and/or dependents lose other group coverage	Add dependents: <ul style="list-style-type: none"> Add dependents losing coverage 	<ul style="list-style-type: none"> Proof of loss of group coverage for each individual being added Birth certificate, paperwork from adoption, legal guardianship or foster placement Marriage certificate, domestic partnership registration Social Security Numbers for all enrolled
	<ul style="list-style-type: none"> Change coverage: Enroll in coverage Coverage option change 	<ul style="list-style-type: none"> Proof of loss of coverage
A Court Order or Qualified Medical Support Order (QMSO)	<ul style="list-style-type: none"> Add self if previously waived Add dependent(s) per court order 	<ul style="list-style-type: none"> Copy of Court Order or QMSO Birth certificate, paperwork from adoption, legal guardianship or foster placement Social Security Number for all enrolled Note: if the employee has waived coverage, the employee AND the child will be added (even if a birth certificate, etc. is not provided)
Change in dependent's residence -- outside of a service area	<ul style="list-style-type: none"> Delete dependent that moved Coverage option change (e.g., Sutter, Western, Kaiser) 	<ul style="list-style-type: none"> Proof of the move (e.g. utility bill in the dependent's name, new drivers' license, etc.)
Change in dependent's residence -- inside of a service area	<ul style="list-style-type: none"> Add dependent that moved Coverage option change (e.g., Sutter, Western, Kaiser) 	<ul style="list-style-type: none"> Proof of the move (e.g. new drivers' license, etc.) Birth Certificate Social Security Number for all enrolled
A gain entitlement for Medicare, Medi-Cal or Medicaid	<ul style="list-style-type: none"> Delete self and/or dependents gaining coverage 	<ul style="list-style-type: none"> Proof of gain of coverage for each individual to be deleted
A loss of entitlement for Medicare, Medi-Cal or Medicaid	<ul style="list-style-type: none"> Add self and/or dependents losing coverage 	<ul style="list-style-type: none"> Proof of loss of coverage Birth certificate, paperwork from adoption, legal guardianship or foster placement Marriage certificate, domestic partner registration Social Security Numbers for all enrolled
A <u>loss</u> of coverage under a group health plan of a government or an educational institution (A gain in coverage is NOT a change in status event)	<ul style="list-style-type: none"> Add self and dependents 	<ul style="list-style-type: none"> Proof of loss of coverage Birth certificate, paperwork from adoption, legal guardianship or foster placement Marriage certificate, DP Registration
A HIPAA special enrollment event – gain or loss of either Medi-Cal or SCHIP	<ul style="list-style-type: none"> Add or delete self and dependents To delete dependents they must have other coverage Add previously eligible, but not yet enrolled dependents Coverage option change 	<ul style="list-style-type: none"> Proof of loss of coverage Proof of gain of coverage Birth certificate, paperwork from adoption, legal guardianship or foster placement Marriage certificate, DP Registration
Change in childcare/eldercare provider or cost or coverage, such as a significant cost increase charged by your current day care provider or a change in your day care provider.	<ul style="list-style-type: none"> Increase, decrease or stop deductions consistent with the change 	<ul style="list-style-type: none"> Proof of increased or decreased cost from day care provider Proof of switch to new day care provider Proof of discontinuance of day care provider use