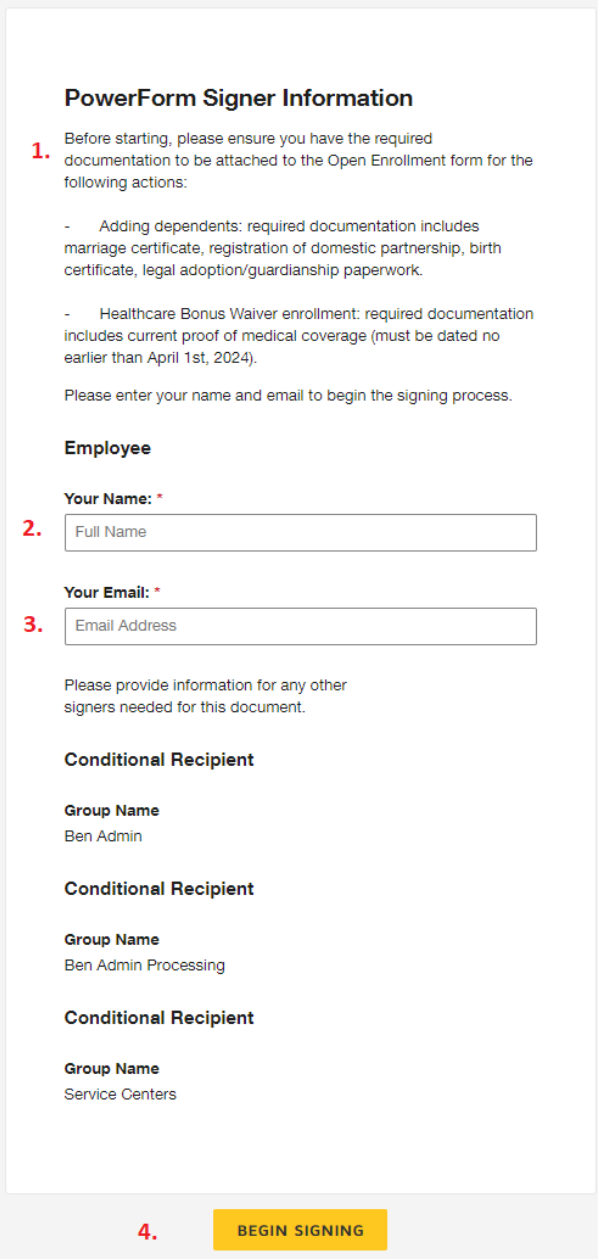
2024 Open Enrollment Instructions

You must complete and submit an online enrollment form to make changes to your benefits.

Navigate to: [2024 Open Enrollment Form]

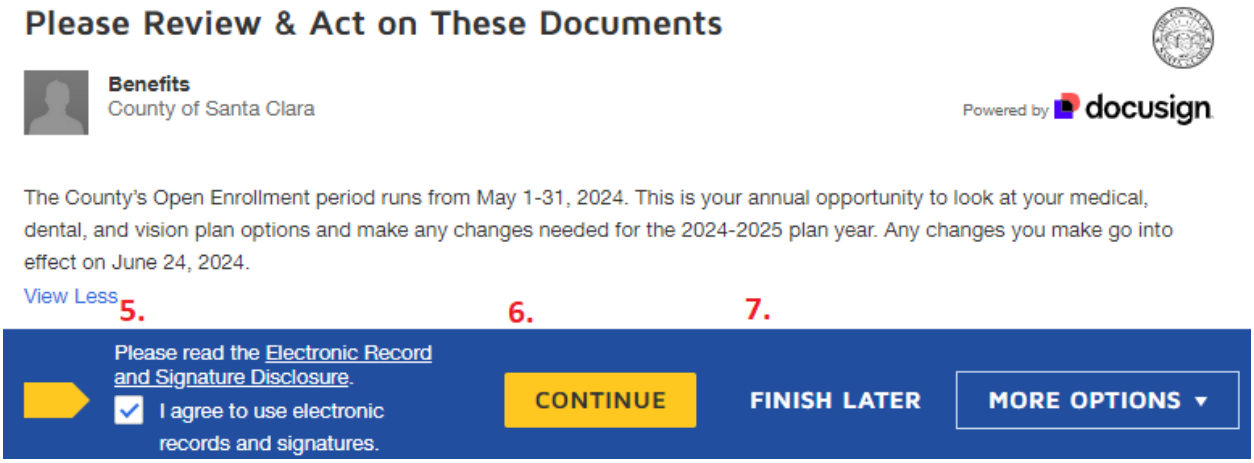


1. Ensure you have the required documentation to be attached to the form.

2. Enter your Name.

3. Enter the e-mail address you would like to use for the signing process. This can be your personal or work e-mail address.

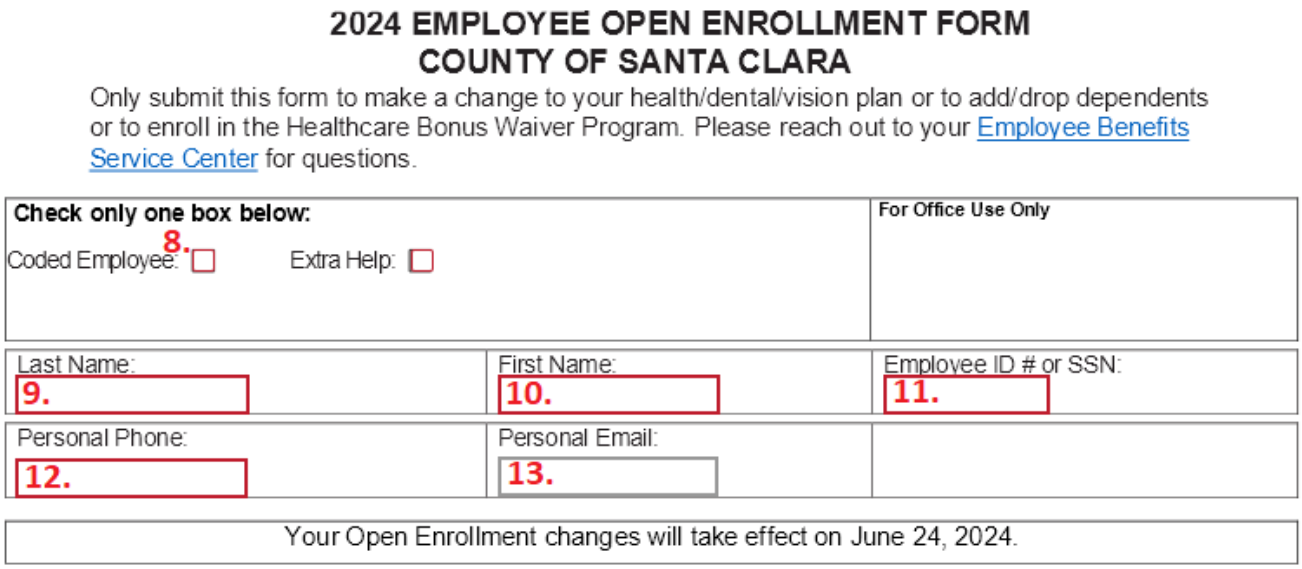
4. Click on [Begin Signing].



5. Click on the checkbox to proceed.

6. Click on [Continue] to proceed.

7. If you are unable to complete the form in a single session, you can use the [Finish Later] button to save your work. This button will remain at the top of the page while your form is in progress.



8. Click on either the Coded or Extra Help checkbox. Do not select both checkboxes. This selection will determine which benefit options are available to you.

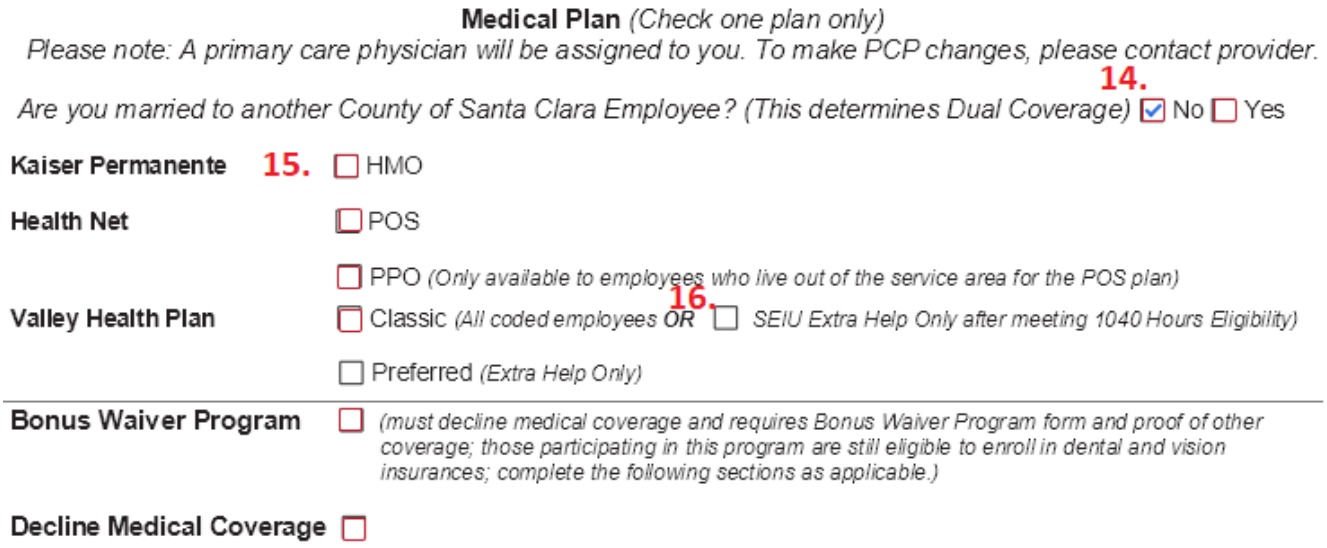
9. Enter your Last Name.

10. Enter your First Name.

11. Enter your Employee ID # or SSN. You can refer to your pay stub if you do not know your Employee ID #.

12. Enter your personal phone number. If we have any questions about your form, we may use this number to contact you.

13. Enter your personal e-mail address. If we have any questions about your form, we may use this e-mail address to contact you.



14. If you are married to or in a registered domestic partnership with another County of Santa Clara employee, click on Yes. Otherwise click on No. Checking "Yes" will activate the Dual Coverage Election Form so you can indicate which employee is covering the family.

15. If you selected "Coded" on Step #8, you may select one of the following Medical options:

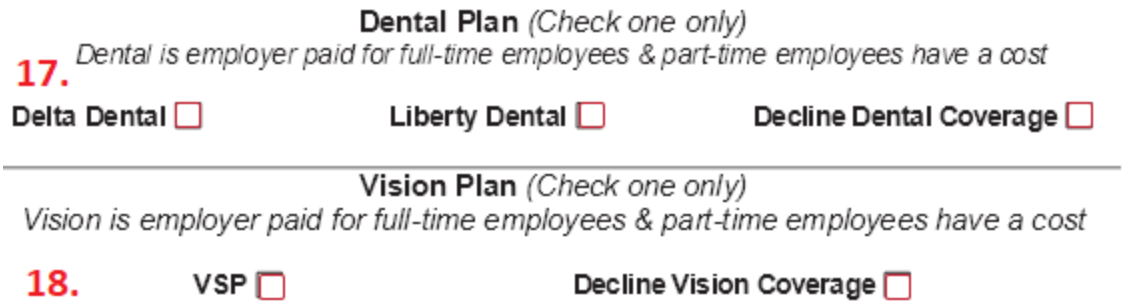
    - Kaiser Permanente HMO
    - Health Net POS
    - Health Net PPO (only available to employees who (or for employees with dependents who) are living out of the service area for the POS plan).
    - Valley Health Plan Classic
    - Bonus Waiver Program
    - Decline Medical Coverage (don't select this option if enrolling in the Bonus Waiver Program)

    Do not select more than one of these options.

16. If you selected "Extra Help" on Step #8, you may select one of the following options:

    - Valley Health Plan - SEIU Extra Help Only after meeting 1040 Hours Eligibility
    - Valley Health Plan Preferred
    - Decline Medical Coverage

    Do not select more than one of these options.

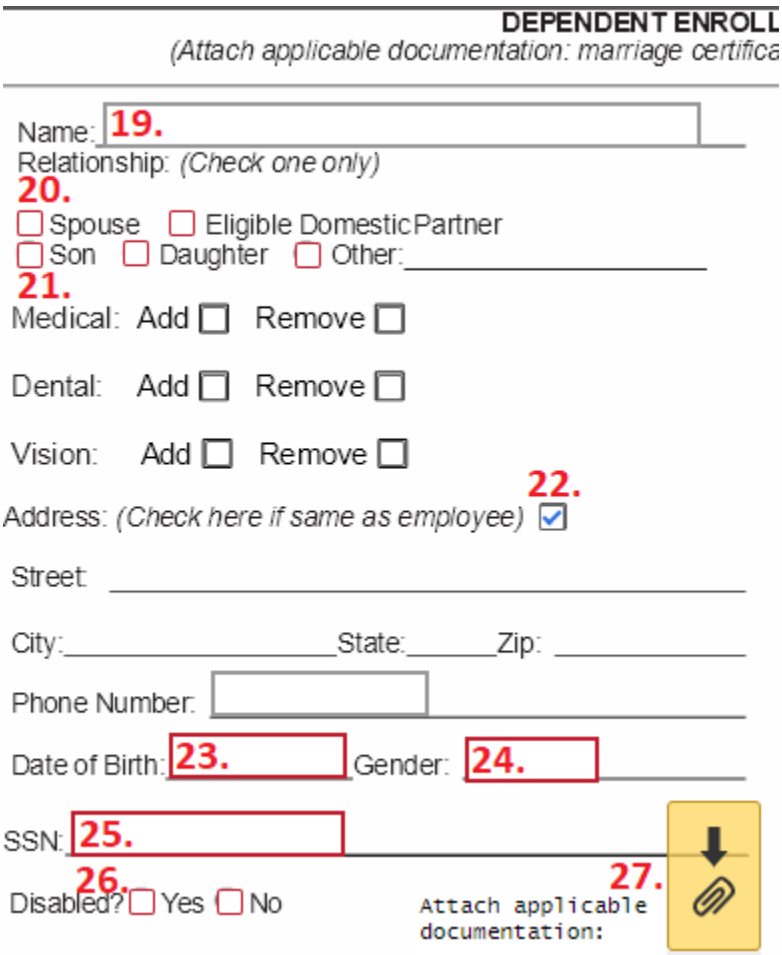


17. If you selected "Coded" on Step #8, you may select one of the following Dental options:

- Delta Dental
- Liberty Dental
- Decline Dental Coverage

18. If you selected "Coded" on Step #8, you may select one of the following Vision options:

- VSP
- Decline Vision Coverage



19. If you are enrolling or removing a dependent, enter your dependent's full name. If you are not enrolling a dependent, skip to Step #29.

20. Enter your relationship to your dependent. Select only one checkbox.

21. Select the action you would like to take for your dependent. Select the Add or Remove checkbox for Medical, the Add or Remove checkbox for Dental, and the Add or Remove checkbox for Vision.

22. Click on the checkbox if the dependent's address is the same as yours. Otherwise, fill in the dependent's address fields.

23. Enter your dependent's date of birth.

24. Enter your dependent's Gender.

25. Enter your dependent's Social Security Number.

26. Select the appropriate checkbox to denote if your dependent is disabled.

27. If you are adding a dependent, you must attach the applicable documentation to prove your relationship status such as:

    - Marriage Certificate
    - Registration of Domestic Partnership
    - Birth Certificate
    - Legal Adoption/Guardianship Paperwork

DEPENDENT ENROLLMENT INFORMATION
(Attach applicable documentation: marriage certificate, domestic partner registration, or birth certificate)

Name: _____	**28.** Name: _____
Relationship: *(Check one only)*	Relationship: *(Check one only)*
○ Spouse ○ Eligible Domestic Partner ○ Son ○ Daughter ○ Other: _____	○ Spouse ○ Eligible Domestic Partner ○ Son ○ Daughter ○ Other: _____
Medical: Add ☐ Remove ☐	Medical: Add ☐ Remove ☐
Dental: Add ☐ Remove ☐	Dental: Add ☐ Remove ☐
Vision: Add ☐ Remove ☐	Vision: Add ☐ Remove ☐
Address: *(Check here if same as employee)* ☐	Address: *(Check here if same as employee)* ☐
Street: _____	Street: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Phone Number: _____
Date of Birth: _____ Gender: _____	Date of Birth: _____ Gender: _____
SSN: _____	SSN: _____
Disabled? ○ Yes ○ No	Disabled? ○ Yes ○ No

28. You must repeat steps 19 – 27 for each dependent you are adding or removing. The form allows up to 8 dependents. If you have more than 8 dependents, please contact your ESA Service Center to assist you in the enrollment process.

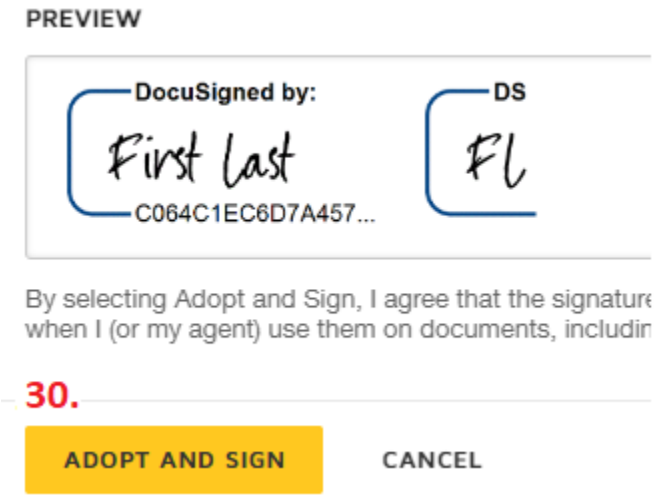
Read and sign if selecting a Kaiser Permanente medical plan:

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

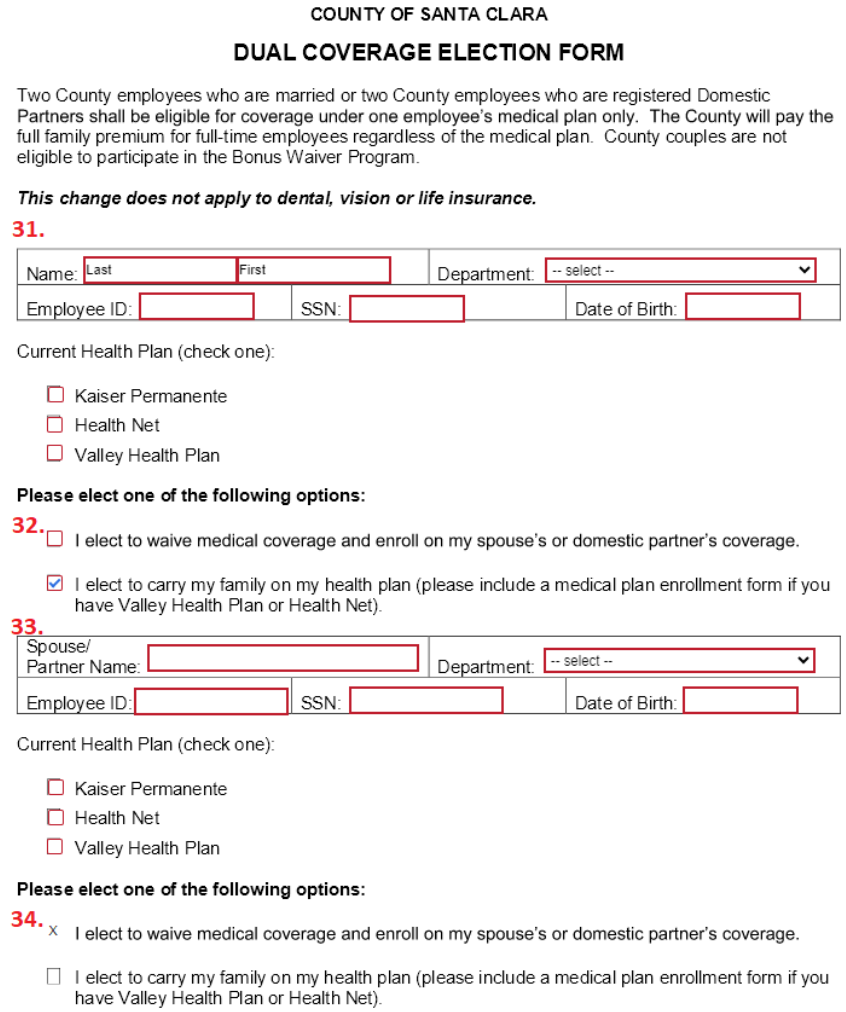
Signature Required for all Kaiser Permanente Plans: **29.** _____ **Date:** 4/15/2024

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

29. You may be prompted to sign one or more forms and disclaimers. Click on each [Sign] button to do so.



30. If this is your first time using Docusign, you may need to click on [Adopt and Sign] to confirm your digital signature.



31. If you are married to or in a registered domestic partnership with another County employee and clicked [Yes] at Step #14, you will be prompted to complete the Dual Coverage Election Form.

32. Click the appropriate checkbox for your situation. You can elect to be enrolled on your spouse or domestic partner's coverage, or you can elect for your spouse or domestic partner to be enrolled on your coverage.

33. Enter your spouse or domestic partner's information.

34. Docusign will automatically select the appropriate option based on the checkbox you selected at Step #32.

35.

HEALTH CARE BONUS WAIVER PROGRAM ELECTION FORM

Employee Name: Last First Normal Biweekly Hours: -- select --

SSN: Employee ID #: (From your Paycheck)

Work Phone #: Home Phone #: 408-123-1234

Employee Dept. Name: Budget Unit #:

Spouse's or Same-Sex Domestic Partner's Name:

Does your Spouse or Partner work for the County of Santa Clara? Yes X No

Name, Address & Telephone # of Spouse's or Partner's Employer:

- I elect to participate in the County of Santa Clara Health Care Bonus Waiver Program.
- While I am enrolled in this program I will receive up to $74 per pay period in taxable earnings (amount is prorated based on standard coded hours).
- ***I acknowledge that I must re-enroll in this program during the annual open enrollment period in order to continue participation each calendar year.***
- I acknowledge that I have been offered the opportunity to enroll myself as well as my eligible dependents in a County sponsored medical plan.
- I hereby decline this opportunity in favor of participation in the Health Care Bonus Waiver Program.
- I acknowledge that I am eligible to enroll in or continue with a County sponsored dental, vision and basic lifeplan. (**If you want dental, vision & life, complete the BEN-02 Form and attach**)
- I certify that medical coverage is provided for myself and eligible dependents under the following plan:

Name, Address & Telephone # of Medical Plan

NOTE: Written documentation that provides proof of medical plan coverage must be attached to this election form. A letter from your spouse's or partner's employer or medical plan provider showing the name of the plan and current dates of coverage is satisfactory proof.

36.

A COPY OF YOUR MEDICAL PLAN CARD IS NOT ACCEPTABLE PROOF OF COVERAGE.

35. If you select Bonus Waiver Program at Step #15, you will be prompted to complete the Health Care Bonus Waiver Program Election Form. Your name, Home Phone number, and marriage status to another County employee, will be copied from your previous answers. You will need to complete the remaining information.

36. Attaching proof of medical plan coverage is required.