Los Angeles Unified School District
Benefits Administration
HEALTH BENEFITS ENROLLMENT FORM – ACTIVE EMPLOYEES

Employee Number	Last Name	First Name	M.I.
| | | | | |			

Address	City	State	Zip Code	Phone Number

Social Security Number	☐ Classified ☐ Certificated	*Do Not Write In Shaded Boxes*	Eff. Date	Process Date	Initial
| | | - | | - | | | |					

HEALTH PLANS *(Please check the plans you wish to enroll in if you are enrolling for the first time)*

MEDICAL

☐ Anthem Blue Cross Select HMO ☐ Health Net HMO ☐ Medical Opt-Out Cash Back
☐ Anthem Blue Cross EPO ☐ Kaiser Permanente HMO ☐ No Medical Coverage

DENTAL

☐ MetLife Preferred Dentist Program (PPO) ☐ MetLife-affiliated Dental Health Care Service Plan (SafeGuard DHMO)
☐ Western Dental DHMO Centers Only ☐ Western Dental DHMO Plan Plus ☐ No Dental Coverage

VISION

☐ EyeMed ☐ VSP ☐ No Vision Coverage

DEPENDENT INFORMATION (Attach additional pages if necessary)

SSN	Last Name	First Name	MI	Relationship	Date of Birth	Sex	Eff. Date
						☐ M ☐ F	
						☐ M ☐ F	
						☐ M ☐ F	
						☐ M ☐ F	

NOTE: Coverage for eligible dependent(s) will begin effective the first day of the following month in which the form and required documentation are received. This application will not be accepted without documentation to verify the dependent status.

SEE NEXT PAGE TO DETERMINE DOCUMENTS NEEDED

Social Security Number is mandatory for all dependents. Newborn: Social Security Number is required within 2 months.

Is your spouse/Domestic Partner a LAUSD employee? ☐Yes ☐No Employee #_____

NO DUAL COVERAGE ALLOWED. SEE REVERSE SIDE FOR ELIGIBILITY RULES.

THIS FORM WILL NOT BE PROCESSED UNLESS SIGNED AND DATED

I understand this election will remain in effect as long as I remain eligible, or until I make another election during an annual enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plans elected. I understand that I am responsible for notifying the District of any change in the eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

Applicant's Signature		Date:

Instructions

In order to assist the District in ensuring that your eligible dependents are properly enrolled under your District-sponsored plan, please read and follow the instructions below.

- **Complete this form, being sure to list <u>all</u> dependents you wish to have added. If necessary, attach an additional sheet of paper to the form.**
  a. List birthdays and Social Security numbers for all dependents. Social Security numbers are mandatory. Social Security numbers for newborns must be provided within two (2) months.
  b. If your spouse/domestic partner is also a District employee/ retiree, please list his or her employee number.
- **Dual Coverage**
  - If you and your spouse are both District employees/ retirees and enrolled in the same plan(s), you may not cover each other as dependents; similarly, only one of you may cover your eligible children under the plan(s).
- **Provide verification of dependent status for dependents as follows:**
  a. Spouse - attach a copy of your marriage certificate issued by the state. For new spouses, if a marriage certificate is received within 30 days of the marriage date, spouse will be covered effective the date of the marriage.
  b. Domestic Partner - complete Declaration of Domestic Partnership form (available from the Health Benefits Administration) and submit the required documentation as outlined in Section II of the Declaration form or submit a copy of your registration with the State. If all of the required documentation is received by Benefits Administration by the 10th of the month, coverage will be effective the first of the following month.
  c. Natural children - attach a copy of official birth certificate for each child. For newborns, if verification of birth is received within 30 days of birth (complimentary hospital birth certificate is acceptable), the newborn will be covered back to date of birth. If submitted more than 30 days but less than 5 months, the newborn will be covered on the first of the month after the verification was received. After a child is 5 months, an official birth certificate is required.
  d. Stepchildren - for each child, attach a copy of the birth certificate and a copy of your marriage certificate (issued by the state), and a copy of your latest income tax return showing the child's dependent status or another form of documentation showing the child is a dependent.
  e. Guardianship/Adopted children - attach a copy of the document verifying legal custody. If you submit verification of guardianship/adoption within 30 days of the guardianship/adoption, coverage will begin on the date of guardianship/adoption. If submitted more than 30 days, coverage will begin on the first of the month after the verification was received.
  f. If you are the legal guardian of a child, please attach a copy of the guardianship papers issued by the court.
  g. Disabled dependent - must meet the disability standards of the plan and must be enrolled prior to age 19, or the dependent child must be enrolled as a full time student prior to the disabling condition.

DEPENDENTS FOR WHOM THE REQUIRED DOCUMENTATION IS NOT RECEIVED WILL NOT BE COVERED UNDER YOUR MEDICAL, DENTAL OR VISION PLAN(S) UNTIL THE APPROPRIATE DOCUMENTATION IS RECEIVED.

EFFECTIVE DATE OF ADDITIONS:
Coverage will begin on the first day of the month following the receipt of the Health Benefits Enrollment form along with the required verification. **Example:** If verification and Health Benefits Enrollment form is received by Benefits Administration on January 1st, the dependent's eligibility becomes effective February 1st.

Basic Life Insurance – Employees are automatically enrolled in the District sponsored Basic Life Insurance option of $ 20,000.
BENEFICIARY - The following order of payment will determine the persons to receive the benefits.
(1) Surviving spouse/ domestic partner of the insured employee; **(2)** Surviving children of the insured employee in equal shares; otherwise, **(3)** Surviving parent(s) of the insured employee in equal shares; otherwise, **(4)**. The estate of the insured.
The beneficiary for dependent coverage and spouse coverage shall be the employee or his/her estate.
If you want to designate a beneficiary for the employee coverage other than as shown above, please contact MetLife at (866) 492-6983.
<u>Visit http://benefits.lausd.net for the Optional Life Insurance Brochure</u> for payroll deducted supplemental life insurance.

TERMINATION OF COVERAGE:
Coverage will be terminated on the last day of the month in which the employee or the dependents became ineligible.

Complete and return this form along with copies of the required documents to:

Los Angeles Unified School District - Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051-1307
Fax: (213) 241-4247 Phone: (213) 241-4262
Email: benefits@lausd.net
Website: http://benefits.lausd.net