Supporting Documentation – Dependent Verification

CalPERS is required under the Affordable Care Act (ACA) to report to the IRS who is enrolled in their health plans. As such, CalPERS requires the employer to obtain and retain social security numbers for covered members and their dependents. CalPERS will use such information for ACA tax compliance purposes.

The following list will help you identify the required documents for each eligible dependent. **Please submit a copy of the social security card for yourself and all dependents listed on your plan**. If you are adding a newborn, you will have 90 days to submit a copy of the social security card. If you are adding an adult who does not have a social security card, you must submit an HBD -12 to be faxed to CalPERS for a CalPERS enrollment. In addition, submit documents as listed below for dependent type:

Health Benefits

☐ **Current spouse -** A copy of your marriage certificate **AND one of the following:**
- ☐ A copy of the front page of your most recent federal or state tax return confirming this dependent is your spouse **OR**
- ☐ A document dated within the last 60 days showing current relationship status, such as a recurring household bill or statement of account if you are recently married (a tax year has not passed). *The document must list your name, your spouse's name, the date and your mailing address.*

☐ **Current registered domestic partner[1] -** A copy of your Declaration of Domestic Partnership **AND one of the following:**
- ☐ A copy of the front page of your must recent federal or state tax return **OR**
- ☐ A document dated within the last 60 days showing current relationship status, such as a recurring household bill or statement of account if you are recently married (a tax year has not passed). *The document must list your name, your partner's name, the date and your mailing address.*

☐ **Natural, adopted, step, or domestic partner's children up to age 26**
- ☐ A copy of the child's birth certificate (or hospital birth record) or adoption certificate naming you or your spouse as the child's parent **OR**
- ☐ A copy of the court order naming you or your spouse as the child's legal guardian.

Note: For a **stepchild**, you must also provide documentation of your current relationship to your spouse or domestic partner as requested above.

[1] Please see Union Contract for acceptable Domestic Partnership relationship. Domestic Partnership is defined as partners of the same-sex *or* partners in an inter-gender relationship if at least one partner is over 62.

☐ **Parent-Child Relation[2] for children up to age 26, for whom the employee assumes a primary parental role who is not his/her adopted, stop, or recognized natural born child** – a copy of the child's birth certificate and the parent child affidavit, and one of the following:

- ☐ Newborn – Nothing more required.
- ☐ Legal Guardian – A copy of the court order naming you or your spouse/domestic partner as the child's legal guardian. If a tax year has passed since the court order you most *also* submit a copy of your most recent tax return.
- ☐ College Student – A copy of your tax return **OR**
  Evidence of full-time student status at an accredited educational institution ***and*** evidence that the child is dependent upon you for more than 50% of the student's support.

Note: Once the child is added to your benefits plan, you will be requested to submit a copy of your tax returns in subsequent years to maintain the child's eligibility. College Students are not mandated to be on your tax returns, but must maintain financial dependence and student eligibility.

Life Insurance

- ☐ Beneficiary Designation – Mandatory submission.
- ☐ Application for Life Insurance – Submit if purchasing additional life insurance.
- ☐ Evidence of Insurability - Submit if purchasing above 120K for employee and/or 50K for Spouse or Domestic Partner.

Waiver of Coverage

- ☐ Waiver of Benefits – Submit if waiving ***one or all*** benefits.

If you have questions, or to get an HBD-12 or a Parent Child Affidavit, please contact the Health Benefits Unit at (888) 4298 – 2980.

Health Benefits Unit

_____	_____
Supervisor	***Date***
_____	_____
Assigned Staff Member	***Date***

[2] A parent-child relationship is defined in the Public Employees' Medical and Hospital Care Act (PEMHCA) at § 599.500, subsection (o) as "intentional assumption of parental status, or assumption of parental duties by the employee or annuitant, as certified by the employee or annuitant at the time of enrollment of the child, and annually thereafter up to the age of 26, unless the child is disabled as described in section 599.500, subdivision (p)." (Note: PCRs do not include foster children.)

Contact Information

LACCD Health Benefits Customer Service
770 Wilshire Blvd
Los Angeles, CA 90017
(888) 428 – 2980
Monday – Friday, 9:00 am – 4:00 p.m.

Email:

- Inter-district email: DO SAP Benefits – Health
- Outside of the district: healthbenefits@email.laccd.edu

Web: http://laccd.edu/Departments/HumanResources/healthbenefits

Medical Plans

Anthem Blue Cross
(855) 839-4524
www.anthem.com/ca/calpershmo

Blue Shield of California
(800) 334-5847
www.blueshieldca.com/calpers

Health Net of California
(888) 926-4921
www.healthnet.com/calpers

Kaiser Permanente
(800) 464-4000
www.kp.org/calpers

PERS Select, PERS Choice, and PERSCare
(877) 737-7776
www.anthem.com/ca/calpers

Sharp Health Plan
(855) 995-5004
www.sharphealthplan.com/calpers

United Healthcare
(877) 359-3714
www.uhc.com/calpers

Dental Plans

Delta Dental
P.O. Box 997330
Sacramento, CA 95899
(800) 765-6003
Group #: 5943
https://www.deltadentalins.com/

MetLife Dental (SafeGuard)
P.O. Box 3594
Laguna Hills, CA 92654
(800) 880-1800
Group #: SGC 1028
https://www.metdental.com

Vision Plan

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7105
(800) 877-7195
Group # (Social Security Number)
https://vsp.com/

FSA/HRA

ADP
Customer Service
1-800-964-6165

Claims Processing
Fax
866-643-2219

General Information
http://www.spendingaccounts.info

Create an account
https://myspendingaccount.adp.com

Wellness Program/Employee Assistance Program

District Site: http://laccd.edu/Departments/HumanResources/Total-Wellness-Program

MHN
1-800-327-0449
https://www.advantageengagement.com
Company Code: laccd

LIFE Insurance

CIGNA Life Insurance
Customer Service 1 (800) -732-1603
Will Preparation: www.CIGNAWillCenter.com

Employee Portal/Employee Self Serve

https://portal.laccd.edu

LOS ANGELES COMMUNITY COLLEGE DISTRICT

ACTIVE & ADJUNCT EMPLOYEES

ENROLLMENT/CHANGE FORM

1. Personal Information

Last *First* *MI*

Social Security Number

Date of Birth

Street Address (no P.O. Boxes)

Home Phone

Work Phone

City *State* *Zip*

Employee Number

Work Location

Status:

☐ Married ☐ Divorced ☐ Widowed

☐ Domestic Partnered ☐ Single

Email Address

☐ Full-time Active ☐ Part-time Adjunct

I want to use my ☐ Home/ ☐ Work address as my benefits services address—the address for my plan[1].

Choose one

2. Reason for Completing This Form -

☐ New Enrollment

☐ Open Enrollment - with prior approval from the health benefits unit. Otherwise, use employee self serve (The Portal).

☐ Name/Address Change

☐ Change in Dependent Coverage

☐ Refusing all health insurance – You will be subject to a waiting period or will be required to verify a recent life status change if you choose to add later.

Event – Life Status Change	Event Date
☐ New Hire/Rehire/Return from Leave	
☐ Marriage/Domestic Partnership	
☐ Dissolution of Marriage/Dom Partner	
☐ Death of Dependent	
☐ Birth	
☐ Adoption/Foster Child Placement	
☐ Parent-Child Relation Established	
☐ Child no longer eligible	
☐ Loss of hours/employment	
☐ Spouse gained or lost coverage (change in employment status)	
☐ Other	

3. Medical Plan

PPO (Anthem Blue Cross)

☐ PERS Care[2]

☐ PERS Choice[3]

☐ PERS Select[3]

HMO

☐ Anthem Select

☐ Anthem Traditional

☐ Blue Shield Access +

HMO, part 2

☐ Health Net Smart Care

☐ Health Net Salud y Mas

☐ Kaiser Permanente

☐ Sharp[4]

☐ United Healthcare

Coverage Type

☐ Employee only

☐ Employee + one

☐ Employee + Family

[1] If you choose an HMO, your benefits services address must be within 30 miles from the physician/hospital that you choose.

[2] PERS Care is a 90/10 coverage plan used in co-ordination with Medicare. ***The employee is responsible for premium payment over and above PERS Choice amount.***

[3] PERS Choice and Select are similar 80/20 coverage plans. The difference is that Select has a smaller physician network.

[4] Not available in Los Angeles County; available only in Southern California Region (San Diego).

NAME: _____ SSN: | | | | | | | | | |

4. Dental Plan

☐ Delta Dental PPO
☐ MetLife Dental HMO (formerly Safeguard)

Coverage Type
☐ Employee only
☐ Employee + one
☐ Employee + Family

5. Vision Plan

☐ Vision Service Plan

Coverage Type
☐ Employee only
☐ Employee + one
☐ Employee + Family

6. Enrollment Information

If you are adding or removing dependents you must submit this form within 60 days of a family status change (new hire, marriage, divorce, birth, etc.) or you may be subject to 90 day penalty period with changes taking effect the first day of the month following the 90 day period.

Please complete the following section for each person you are enrolling, including yourself. If you are enrolling more than three children, please list their names and information on a separate page. Sign, date, and attach that page to this form.

Enrollee	Add	Delete	Name (Last on top line, First, MI)	Gender	Birth Date	Soc. Security #
Self	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Spouse/ Dom Partner	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				
Child	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision				

7. Dual Coverage

☐ My spouse/domestic partner is an LACCD employee/retiree. His/her employee number is: _____ .

☐ I understand that I and/or my dependents can only have one health plan administers by CalPERS. Further if I and/or my dependents am/are determined to be on another CalPERS plan, I/we can not enroll into LACCD's health benefits plan until I/we dis-enroll from the other CalPERS plan. [5]

NOTE: If CalPERS rejects your enrollment through LACCD due to dual enrollment (CalPERS administered benefits sponsored by another agency) you will not be added to health benefits until the dual coverage issue is corrected.

[5] An employee may be enrolled as an enrolled CalPERS primary insurance carrier or as a dependent of another CalPERS enrollee or retiree, but not both. An individual may be included as a dependent under the enrollment of only one employee or retiree.

NAME: _____ SSN: | | | | | | | | | |

8. Flexible Spending Account

LACCD partners with Automatic Data Processing (ADP) to provide pre-tax Flexible Spending Account Services for our employees. Funds are deducted from January – December of the Calendar year with no deductions taken during the summer. ***Plan your deduction expenses accordingly*** because you will only be allowed to roll over up to 500.00 of unused funds at the end of the calendar year. Please visit ADP's website (www.spendingaccounts.info) to find out more about the plan, administration of the plan, and about eligible expenses.

NOTE: There is a calendar year maximum amount that can be contributed to each plan. The maximum dependent care contribution is 5,000.00 and the maximum Health Care contribution is 2,500.00.

_____ I would like to set aside _____ this calendar year for Dependent Care expenses.
initial

_____ I would like to set aside _____ this calendar year for Health Care expenses.
initial

9. Life Insurance - Part time Faculty NOT ELIGIBLE

You are entitled to a 50,000.00 Life and Accident & Death policy with premiums paid by LACCD. In addition, you are entitled to purchase additional insurance for yourself and any dependents that you have. Please review the life insurance forms and make the appropriate selections for your needs. Even if you choose not to purchase additional coverage, you must submit a beneficiary designation for the Basic Coverage that LACCD provides.

_____ Life Insurance forms and/or Beneficiary Designation attached.
initial

- Beneficiary – The person(s) who inherits the claim should it be activated.
- Contingent beneficiary – The person(s) who inherits the claim as a secondary person if the beneficiary can not be located.
- If you choose life insurance for your spouse, you much purchase at least twice that amount for yourself.
- Life insurance is measured by units: 10,000.00 is 10 units, 5,000.00 is 5 units, etc. If you purchase voluntary life insurance, you find the cost according to your age and multiply by the number of units that you want to purchase.
- Life insurance for your spouse/dom partner is based on your age, not your spouse/dom partner's age.
- As a new employee, you may select insurance up to 120,000.00 for yourself and 50,000.00 for your spouse without submitting a Statement of Health (SOH). If you choose insurance ***above*** 120,000.00 (or 50,000.00 spouse/dom partner), you must submit a SOH. After status of new employee (60 days or more), you may only increase/decrease during open enrollment. At which time, you must submit a statement of health.

_____ I decline life insurance. I understand that I am not responsible for the premium for LACCD's Basic Life insurance policy, and am choosing to decline this benefit with full understanding of this fact.
initial

10. How to Submit this Enrollment/Change Form (Part 1)

In order to enroll or change your plan, you must:

1. Complete *and* Sign this form.
2. If you are submitting this form for any event other than Return from Leave you must provide supporting documents. Acceptable documents must prove the event that you are claiming. This can include a marriage license or State of California Domestic Partner Registration[6], court papers (divorce/dissolution decree, adoption or child care papers), certificate of death, birth certificate, or COBRA Letter from previous employer showing that job status change caused loss of insurance. In addition to those documents, **we require a copy of the social security card for all participants**.

[6] Please see your union contract for definition of acceptable Domestic Partner.

NAME: _____ SSN: | | | | | | | | | |

10. How to Submit this Enrollment/Change Form (Part 2)

3. If you have questions as to which documents are needed for verification, contact the Health Benefits Unit by telephone at (888) 428-2980 or via email at healthbenefits@email.laccd.edu
4. Send this form and the attached PHOTOCOPIES of supporting documents using ***one*** of the following methods:

US Mail
LACCD Health Benefits Unit
770 Wilshire Blvd., 6th Floor
Los Angeles, CA 90017

Secure Fax
Health Benefits Unit
(213) 891-2008

Courier
District Office
Health Benefits Unit
6th Floor

Email
healthbenefits@email.laccd.edu

_____ ***initial*** I understand that the elections I make on this form will remain as long as I am eligible or until I make another election during annual enrollment. I am enrolling for myself and those eligible dependents that I have listed in Part 6 of this form for coverage under the plan(s) I have selected.

_____ ***initial*** ***I understand that I am responsible for reporting any change(s) in the eligibility status of my dependents within 60 days***. Further, if I fail to report status changes within 60 days, I understand that I could be liable for retroactive premium payments in excess of the amount of my plan if I had reported the change in time, and I further understand that I could be liable for medical expenses incurred by the ineligible party.

_____ ***initial*** I understand that missing documentation will result in a delay in processing that will leave me and/or my dependents without coverage until all information is submitted, and I further understand that my benefits become effective the first day of the month *after* I submit all documents to complete the enrollment process.

_____ ***initial*** I understand that if I enroll in PERSCare, I will pay part of the premium. The difference between PERSCare and PERS Choice will be deducted from my paycheck

_____ ***initial*** ***For New Employees: I understand that I must submit my application for enrollment and insurance papers within 60 calendar days of being hired and that my benefits will begin on the first of the month after the Health Benefits Unit receives my application. I further understand that if I submit my documents after the first 60 calendar days then I will be subject to a 90 day waiting period before my benefits become effective, with benefits becoming effective the first day of the month following the waiting period.***

X _____ _____
Signature ***Date***

FOR HEALTH INSURANCE SECTION USE

☐ Medical
☐ Dental
☐ Vision
☐ Life Insurance

☐ Emp Assistance Program
☐ Life Insurance
☐ HRA Card* (if benefits begin on or before 3/1)
* Adjuncts are not eligible for the HRA or life insurance

Event Date: _____
Date Processed: _____
Processed By: _____

LOS ANGELES COMMUNITY COLLEGES

CITY ◆ EAST ◆ HARBOR ◆ MISSION ◆ PIERCE ◆ SOUTHWEST ◆ TRADE-TECHNICAL ◆ VALLEY ◆ WEST

Administrative Offices

Dear Employee:

You are entitled to a 50,000 life insurance policy with premiums paid by LACCD. In addition, you're entitled to purchase additional life insurance for yourself and your dependents. Please review the attached documents, including the brochures explaining the plans and the rates, make a decision as to whether additional insurance is for you, and submit documents as they meet your needs:

1. Beneficiary Designation
    a. Mandatory because you have to designate someone as a beneficiary to your Basic LACCD plan. Please, also, include a Contingent Beneficiary.
    b. A Contingent is someone to receive the inheritance if we can't locate the Beneficiary.
2. Application for Insurance – If you choose to purchase additional insurance for yourself and your dependents.
3. Statement of Health – If you choose to submit insurance above the guaranteed amount for yourself and your spouse.

NOTES:

1. In order to purchase life insurance for a spouse you must purchase at least twice that amount for yourself.
2. LACCD has a guaranteed amount of insurance that you can purchase for yourself and for your spouse without having to submit a physician's report; it is 120,000.00 for you and 50,000.00 for your spouse. If you purchase over that amount, you must submit a Statement of Insurability.
3. In order to calculate your premium for yourself 1) Find the Premium Rate based on your Age, 2) Determine the number of units by knowing that each 1,000.00 of insurance equals 1 unit, and 3) Multiply the Age Premium times Number of Units:
    a. EE is 45. Rates for a 45 year old is .202 cents.
    EE wants $120,000.00.
    $120,000.00 = 120 Units.
    b. AgeRate x #ofUnits = Amount per month
    .202 x 120 = $24.24.
4. To determine the premium for a spouse, use the formula above. Premium for spouse is based on ***your*** age.
5. To determine the premium for your child (or children) the rate is .185; one rate covers one or multiple children.
6. You're entitled to add accident coverage to your life insurance. The premium is .017 for each unit and the insurance will be for the same number of units that you purchase for voluntary life insurance.

(Over)

770 Wilshire Blvd, Los Angeles, California 90017-3856 ☎ (888) 428 – 2980 do-sap-benefits-health@email.laccd.edu

a. You can not purchase accident insurance without purchasing life insurance.
b. You must purchase the same number of units for accident as for life.
c. You can not purchase accident insurance for your dependents.

7. Fax the completed documents to (213) 891 – 2008.

If you have questions, you may contact the health benefits at (888) 428-2980 and any of the health benefits employees can answer your questions.

VOLUNTARY LIFE INSURANCE RATES

Benefit	Premium Rate
Voluntary Term Life Employee	See the following Step-Rate Table
Voluntary Spouse	See the following Step-Rate Table
Voluntary Child	$0.185

VOLUNTARY LIFE INSURANCE STEP TENTHLY RATES FOR EMPLOYEE/SPOUSE

Age	Employee and Spouse Tenthly Rates
<20	$0.054
20-24	$0.054
25-29	$0.054
30-34	$0.072
35-39	$0.082
40-44	$0.125
45-49	$0.202
50-54	$0.320
55-59	$0.540
60-64	$0.722
65-69	$1.354
70-74	$2.701
75-99	$3.472

Rates are guaranteed for 3 Years

LACCD Health Benefits Unit

BENEFICIARY DESIGNATION FORM
Life Insurance Company of North America

Employer Name Los Angeles Community College District
Employee Name _____ Employee Social Security # _____
Current Address _____ City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____ ***please enter all dates in mm/dd/yyyy format***

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-965530				
Employee's Primary Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	

Voluntary Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-965530				
Employee's Primary Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	

Voluntary Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-965530				
Spouse's/Domestic Partner's Primary Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	
Spouse's/Domestic Partner's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Address:			**Phone Number:**	
Address:			**Phone Number:**	

Voluntary Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-965530				
Child(ren)'s Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Basic Accident Insurance, Life Insurance Company of North America - Policy No. OK-967109				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Voluntary Accident Insurance, Life Insurance Company of North America - Policy No. OK-967109				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	

If you need additional space using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Note: This form is not complete without your signature. Please sign the form where indicated.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____/____/_____

Owner Signature _____ Date _____/____/_____

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Blank

INSURANCE APPLICATION

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.
- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: *Please enter all dates in mm/dd/yyyy format.*

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.

EMPLOYER Los Angeles Community College District

CLASS _____ **LOCATION/PAYCODE#** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/DOMESTIC PARTNER
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

Please print (preferably in black ink).

EMPLOYEE SECTION

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ☐ M ☐ F

Important: You must complete the medical questions in this application if you apply for life insurance: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) above the Guaranteed Coverage Amount.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

☐ I am currently married and my date of marriage is _____ *–or–* ☐ I currently have an eligible Domestic Partner

Spouse or Domestic Partner Information

Name (First) _____ (Last) _____ Social Security # _____

Birthdate _____ Sex: ☐ M ☐ F

TERM LIFE INSURANCE — POLICY NO. FLX-965530

	Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Voluntary Employee-Paid Coverage	Employee	☐	☐ Number of $10,000 units _____	Lesser of 5 times annual salary or 120,000
	Spouse/Domestic Partner	☐	☐ Number of $5,000 units _____	$50,000
	Child(ren)	☐	☐ Number of $1,000 units _____	$10,000

**Guaranteed Coverage Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.*

ACCIDENT INSURANCE — POLICY NO. OK-967109

If you elect voluntary accident insurance, the coverage amount must be equal to the voluntary life insurance benefit in effect under Policy Number FLX-965530, underwritten by Life Insurance Company of North America.

BENEFICIARY

To ***specify a beneficiary***, complete the section below. You will be the beneficiary for your spouse/domestic partner and child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Insured	*Beneficiary*	*Percentage*	*Social Security #*	*Date of Birth*	*Relationship*
Employee *(Life)*					
Employee *(Accident)*					

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Signature _____ Date _____

Please Sign Here

Important: **You must also sign and date the Agreements section on the back of this form.**

Be sure to make a copy of your application for your own records.

Applicant's Name _____ **Social Security #** _____

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse/domestic partner information in this section if you (i.e., the Employee) or your spouse/domestic partner are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee	**Spouse/Domestic Partner**
Height ft in	Height ft in
Weight lbs	Weight lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse/Domestic Partner Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee		Spouse/ Dom. Part.	
		Yes	No	Yes	No
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑	❑	❑
B.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑
E.	HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G.	Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION B

Within the last 5 years has the proposed insured:

A.	Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B.	Smoked cigarettes:	❑	❑	❑	❑
	1. For how many years has the proposed insured smoked?				
	2. Approximately how many cigarettes are, or were, smoked on average per day?				
	3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C.	Used any controlled or illegal drug or other substance?	❑	❑	❑	❑
D.	Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑	❑	❑
E.	Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑	❑	❑
F.	Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑	❑	❑

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee, Spouse/Domestic Partner	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

***Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

***Important:* You must also sign and date the Agreements and Authorization section.**

Fold and staple this page to conceal health questions.
Return application to your employer. Be sure to make a copy for your own records.

Applicant's Name _____ **Social Security #** _____

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Sign Here

_____	_____	_____	_____
Employee's Signature	*Month/Day/Year*	*Spouse/Domestic Partner's Signature (If applying for insurance for your spouse/domestic partner)*	*Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

TL-009320 (**CA**)

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EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: *Please enter all dates in mm/dd/yyyy format. . Please print (preferably in black ink).*

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.

EMPLOYER Los Angeles Community College District **Policy** FLX-965530

CLASS _____ **LOCATION/PAYCODE #** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/DOMESTIC PARTNER
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

EMPLOYEE SECTION

❑ Mr. ❑ Mrs. ❑ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ❑ M ❑ F

In order to confirm your election, please provide your signature: _____ Date _____

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

☐ I am currently married and my date of marriage is _____ *–or–* ☐ I currently have an eligible Domestic Partner

Spouse/Domestic Partner (First) _____ (Last) _____ Social Security # _____

Birthdate _____ Sex: ☐ M ☐ F

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse/domestic partner information in this section if you (i.e., the Employee) or your spouse/domestic partner are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee				Spouse/Domestic Partner			
Height	ft	in	Weight lbs	Height	ft	in	Weight lbs

PHYSICIAN SECTION

Employee Physician Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse/Domestic Partner Physician Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee Yes	Employee No	Spouse/ Dom. Part. Yes	Spouse/ Dom. Part. No
A.	High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑	❑	❑
B.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D.	Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑
E.	HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F.	Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G.	Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H.	Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑	❑	❑

Fold and staple to conceal health questions. Return application to your employer. Be sure to make a copy for your own records.

Name _____ **Social Security #** _____

SECTION B

Within the last 5 years has the proposed insured:

		Employee		Spouse/ Dom. Part.	
		Yes	No	Yes	No
A.	Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B.	Smoked cigarettes:	❑	❑	❑	❑
	1. For how many years has the proposed insured smoked?				
	2. Approximately how many cigarettes are, or were, smoked on average per day?				
	3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C.	Used any controlled or illegal drug or other substance?	❑	❑	❑	❑
D.	Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑	❑	❑
E.	Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑	❑	❑
F.	Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑	❑	❑

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee, Spouse/Domestic Partner	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

***Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

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☛

Sign Here

_____ *Employee's Signature* _____ *Month/Day/Year*

_____ *Spouse/Domestic Partner's Signature* _____ *Month/Day/Year*
(If applying for insurance for your spouse/domestic partner)

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Return to your employer. Be sure to make a copy for your own records.

Declination of LACCD Health & Life Benefits

LACCD offers dental, medical, vision, and basic life benefits plans to all of its employees and their dependents.

Each employee has the right to decline any of these benefits. **If you decline health and/or life benefits, you will only be able to elect benefits in the future either during annual Open Enrollment or in the event that you experience a qualifying life changing event.**

By completing this Declination of Benefits form, I hereby acknowledge that I have been offered dental, medical, vision, and basic life insurance benefits by LACCD.

I **decline dental** benefits through LACCD for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren)

I **decline medical** benefits through LACCD for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren)

I **decline vision** benefits through LACCD for:

☐ Myself ☐ Spouse ☐ Dependent Child(ren)

☐ I decline basic life and AD&D benefits.

I understand that by declining health and/or life benefits at this time, that **I will not be covered** by LACCD dental, medical, vision, and/or basic life benefits unless I later complete applications for such either during Annual Open Enrollment or in the event I experience a qualifying life changing event that allows me to enroll outside of the Annual Open Enrollment Period.

Name: _____ Employee # _____

Signature: _____ Date _____

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