San Joaquin County Health and Life Insurance Enrollment Forms

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Please submit completed forms in this packet directly to the San Joaquin County Human Resources Benefits Unit.

<u>Forms can be submitted by:</u>

- Email: employeebenefits@sjgov.org
- Interoffice Mail
- USPS Mail
- In Person:
  - San Joaquin County Administration Building 44 N. San Joaquin Street Suite #330 Stockton, CA 95202

- **All employees must submit an Enrollment Forms**
  - ***If opting out*** of benefits, submit the form with "Opt-Out Medical" selected for each plan.
- County Benefits team ***does not*** issue insurance cards
- Employees will receive medical cards through the selected provider
- Delta Dental and VSP ***does not*** provide cards
- Providers receive processed benefits a week ***after*** the effective date
  - **Example:** If your benefits start on April 6, the provider may not have them visible in their system until around April 23.
  - Your benefits are active as of the effective date, but it can take some time for the provider to reflect the update in their system.

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San Joaquin County Health Benefits Enrollment Form 2025 – 2026

Employees Units: **A** (Executive Non-Caf), **B** (Senior Management Non-Caf), **C** (Middle Management Non-Caf), **D** (Confidential Non-Cafeteria), **E** (Professional), **F** (Para-Professional & Technical), **G** (Office & Office Technical), **H** (Safety, Investigative & Custodial), **I** (Trades, Labor, and Institutional), **K** (Sheriff Deputies), **M** (Registered Nurses), **N** (Correctional Officers), **O** (Elected Officials), **P** (American Physicians and Dentists), **Q** (Peace Officers Misc.), **R** (Supervisors), **S** (Unrepresented Physicians), **T** (Attorneys), **U** (Probation Officers), and **X** (Unassigned CRNAs Only)

Reason: ☐ Open Enrollment ☐ New Hire ☐ Qualifying Life Event: ____________________________ HR staff only/Date: ________

All required documents must be received before this form is processed.
For any questions or to submit this form, contact Human Resources Employee Benefits Office at (209) 468-9987
Email: employeebenefits@sjgov.org. Fax: (209) 468-9734. Mailing address: 44 North San Joaquin Street Suite 330, Stockton, CA 95202

Employee Personal Information			
First Name, Middle Initial, Last Name:		Employee ID#:	
Street Address:	City:	State:	Zip Code:
Date of Birth:	Social Security Number:		
Best Contact Phone Number:	☐Mobile ☐Home		☐Male ☐Female
Email Address:			

Medical Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Medical Plan Options	Coverage Level
☐Select Exclusive Plan ☐Select Plan ☐Premier Plan ☐Sutter Health Plus HMO ☐Kaiser Permanente HMO ☐Sutter Health Plus – High Deductible Health Plan (HDHP) ☐Kaiser Permanente – High Deductible Health Plan (HDHP) ☐ No Changes	☐Employee ☐ Employee + One ☐Employee + Family **☐Opt-Out of Medical**

Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
Select Exclusive	$164.65	$329.31	$461.04
Select Plan	$164.65	$329.31	$461.04
Premier Plan	$233.78	$467.57	$654.57
Sutter Health Plus HMO	$92.58	$185.16	$261.99
Kaiser HMO	$91.80	$183.60	$259.80
Sutter Health Plus HDHP	$69.58	$139.17	$196.93
Kaiser HDHP	$70.25	$140.50	$198.80

-Employee's Primary Care Physician (PCP) code for Sutter Health Plus (required):
-Go to www.sutterhealthplus.org/provider-search to find a PCP or one will be auto-assigned to you)

Dental Plan Options

Check the box next to the Plan you desire and check the box for the coverage level.

Dental Plan Options	Coverage Level
☐Delta Dental (Standard) ☐Delta Dental (Core) ☐Delta Dental (Buy Up) ☐United Healthcare Dental ☐ No Changes	☐Employee Only ☐Employee + One ☐Employee + Family **☐Opt-Out of Dental**

Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
Delta Dental (Standard)	$0.00	$16.26	$38.90
Delta Dental (Core)	$0.00	$15.78	$37.73
Delta Dental (Buy Up)	$0.91	$18.05	$41.90
UHC Dental	$0.00	$12.43	$23.40

Vision Plan Option

Vision Plan	Coverage Level
☐VSP (Standard) ☐VSP (Buy Up) ☐Opt-Out of Vision ☐ No Changes	☐Employee Only ☐Employee + One ☐Employee + Family **☐Opt-Out of Vision**

Bi-Weekly Rates	Employee Only	Employee + One Dependent	Employee + Family
VSP (Standard)	$0.00	$2.35	$6.05
VSP (Buy Up)	$1.80	$5.95	$12.51

Only for High Deductible Health Plans: Health Savings Account (Optional)

The County will contribute $700 annually (divided by 26 pay periods) towards an employee's Health Savings Account (HSA) who elects a High Deductible Health Plan (HDHP) at the employee only coverage level. The County will contribute $1,400 annually (divided by 26 pay periods) towards an employee's HSA who elects a HDHP at the employee + one or employee + family coverage level. Employees have the option to contribute the difference between the annual maximum and what the County is contributing on a pre-tax basis. This plan is similar to the Flexible Spending Account as you are able to pay for qualifying health expenses. For more information on this plan, call (833) 232-4673 or email voyasupport@voya.benstrat.com

Enter the annual election for the plan you desire. These deductions cannot be used to pay for insurance premiums. Your annual amount will be divided between the remaining number of pay periods in the calendar year you are electing coverage for.

Indicate the election change by checking the appropriate box below.

☐ Cancel Future Contributions to the HSA	
☐ Begin Contributions (First HSA Contribution this year)	$ __________ Optional Annual Employee Contributions to the HSA
☐ Change Contributions	$ __________ Optional Annual Employee Contributions to the HSA

The IRS has established annual limits that can be contributed to a Health Savings Account in 2025, which are $4,300 for single coverage and $8,550 for 2-Party or Family coverage (including the County's Contribution of $700 for employee only or $1,400 for employee + one/employee + family).

IMPORTANT:

In order to open a Health Savings Account (HSA) and have tax-free contributions made to that account, you must be "HSA Eligible." **IRS guidelines define an HSA Eligible individual as a person who:**

- **is covered under a HSA-qualified high-deductible health plan (HDHP), and**
- **has "no other health coverage" (except what is permitted by the IRS), and**
- **is not enrolled in Medicare, and**
- **cannot be claimed as a dependent on someone else's tax return.**

By law, you are not eligible for HSA contributions if you:

- are enrolled in Medicare* (Part A, Part B, Medicare Advantage Plans, Part D, and Medigap/Medicare Supplemental Insurance),
- are covered by another health care plan that is not a qualified high deductible health plan (HDHP),
- can be claimed as a dependent on someone else's tax return,
- are covered by a non-HDHP such as Medicaid, TRICARE or TRICARE for Life, or
- are enrolled in a general-purpose Health Care Flexible Spending Account or Healthcare Reimbursement Account (or covered by a spouse's FSA or HRA).

*With respect to being enrolled in Medicare, if you are enrolling in Medicare after attaining age 65, **HSA contributions generally should be discontinued at least six (6) months prior to filing for Medicare benefits**, because Medicare enrollment (called Medicare entitlement) can occur retroactively if you apply after you attain age 65. In such case, if you do not stop HSA contributions in a timely fashion, i.e., the six (6) months (or the months between turning age 65 and the date of application, if shorter) before you apply for Social Security (applying for Social Security is a first step toward Medicare coverage), you may have made an excess contribution and incur a tax penalty.

Information about Health Savings Account Contributions and Prorating the Maximum Yearly Contribution: If you aren't certain you'll be enrolled in a HDHP during the entire next tax year, you can contribute a prorated amount for the months you're eligible in the current tax year. To do this, divide the yearly allowable maximum contribution by 12, then multiply the result by the number of months you're enrolled in a HDHP during that tax year.

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your HDHP. If you are enrolled in the HDHP as of December 1, you are not required to prorate your contributions to your health savings account and can make the full year's contribution to your HSA account. However, if you base an entire tax year's contribution on your status on December 1 (and you were not HSA eligible for that entire year) and you cease to be an eligible individual before the end of the following year, any funding of the HSA over the prorated amount for the months of actual eligibility in the prior year is considered an excess health savings account contribution and the excess amount is subject to a penalty and income tax.

A few states including California may not conform their state tax laws with federal tax laws and contributions to the HSA may be taxed under these state laws. It is advisable to discuss with your tax advisor about joining a HDHP with HSA. Remember, **it is your responsibility to assure that you are an "HSA eligible" individual while contributions are made to your HSA.**

I understand that the County of San Joaquin will contribute to a health savings account (HSA) on my behalf, I must meet all of the following conditions for HSA eligibility:

- **I am covered under the County's Kaiser or Sutter Health Plus HSA-Qualified High Deductible Health Plan (HDHP), and**
- **I have "no other health coverage" (except what is permitted by the IRS), and**
- **I am not entitled to Medicare, and**
- **I cannot be claimed as a dependent on someone else's tax return.**

By signing below, I certify that all of the above statements are true. I agree to promptly notify the County of San Joaquin Human Resources Employee Benefits Office in writing if I cease to meet these conditions. I understand that the County will make contributions to my HSA only on the basis of my certifications, and that HSA contributions are subject to certain limits under federal tax law. **I further acknowledge that employee contributions are taken out of my pay check on a pre-tax basis, and that a monthly administrative fee (currently $1.15 per month) will be deducted from my HSA account. Additional fees also apply if I utilize VOYA's optional investment account options within my HSA account.**

Signature: ____ Date______________________________

SECTION 125 FLEXIBLE SPENDING ACCOUNT/ DEPENDENT DAY CARE

As of February 23,2026, **San Joaquin County Benefits Division is no longer the overseer of the Medical Flexible Spending Account or Dependent Day Care**.

If you want to enroll in the Medical Flexible Spending Account or Dependent Day Care. Please contact American Fidelity directly at 800-662-1113 or americanfidelity.com/fsa.

For more information on enrolling in these optional plans, please visit our website at Benefits Division | sjgov.org

Eligible Dependent Coverage

Check the box for the health services you wish to enroll your eligible dependents. You, as the employee, must be enrolled in the plan if you want your dependent(s) enrolled. If your dependents are enrolled, the plan selection(s) must be the same as the employee.

Required Documentation:
Social Security Number for all, Marriage Certificate (spouse), Birth Certificate (child), Certificate of Partnership (registered domestic partner), court paperwork (adopted child/legal guardianship)

Dependent(s) Name (spouse and/or children)	Relation-ship	Date of Birth	Social Security Number (required)	Medical	Dental	Vision	Primary Care Physician

Other Medical Coverage:

Is your spouse or any of your eligible dependents covered by another group medical plan, including San Joaquin County coverage, MediCal, or Medicare?

☐Yes. Name and Address of Other Medical Coverage____

☐No. I certify that my spouse and/or dependents are not covered by any other medical coverage.

Kaiser Foundation Health Plan Arbitration Agreement: Please read and sign if you are electing the Kaiser plan **(required)**.

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with Employee Retirement Income Security Act regarding certain benefit related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 be lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my 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.

Employee Signature **Date**

Sutter Health Plus Plan Arbitration Agreement: Please read and sign if you are electing the Sutter Health Plus plan **(required)**.

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration

Sutter Health Plus (SHP) handles/resolves member disputes through grievance, appeal and independent medical review processes. In the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes. As a condition of your membership in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *EOC*.

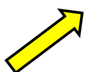
Employee Signature **Date**

Qualifying Life Events

If you have a qualifying life event, you must provide proof within 60 days of the event. If you obtain a new dependent (through marriage, birth, adoption, registered domestic partnership, legal guardianship) or if you or your dependents lose medical, dental, and/or vision coverage, you must request enrollment in the County's plans within 60 days of the date of the event. If you do not request enrollment within 60 days, you or your dependent must wait until the next County Open Enrollment period before you can enroll and/or make changes. It is also the employee's responsibility to delete a spouse or dependent from coverage within 60 days of an event that makes the dependent ineligible for benefits (such as divorce or over-age child).

By signing below, I acknowledge that deductions are taken out of my pay check on a pre-tax basis. I must provide all dependent verification documentation within 60 days from my date of hire or qualifying life event. Rates are negotiated through my bargaining unit and approved by the Board of Supervisors. All dependents enrolled must be eligible. I understand that falsification of information by me will allow my employer to recover payments made, cancel my coverage, refuse payment of claims, and may include discipline.

Signature: ____ **Date:** __________________________________



Please do not forget to sign here!

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Public Risk Innovation, Solutions and Management (PRISM) Effective Date of Coverage or Change ____________
Group/Plan Number 316407 Account Number/Location **039 - County of San Joaquin**
Class/Occupation ____________
Date of Hire ____________ Annual Salary $____________ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to *(Check all that apply.)*:
☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other ____________

[1] A late entrant is an individual who is first enrolling after the initial available opportunity.

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* ____________
Birth Date ____________ SSN ____________ Gender: ☐ Male ☐ Female
Employee ID Number ____________ Work Phone (______)____________ Home Phone (______)____________
Address ____________ City ____________ State ______ ZIP ______

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☑ Employee Only—Elect Coverage *(Note: Basic Life and Basic AD&D insurance is employer provided.)*

Supplemental Life / AD&D Insurance

Guaranteed Issue (GI) Limit = $100,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to $200,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life / AD&D Insurance Election

☐ I currently have supplemental life coverage of: $____________.
☐ I am applying for additional supplemental life coverage of: $____________. *($25,000 increments)*
☐ Total supplemental life coverage (current plus additional): $____________.
☐ Waive coverage.

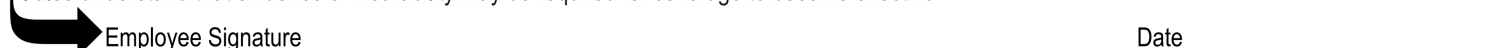
BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- 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 by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.



Employee Signature ____________ Date ____________

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

GROUP TERM LIFE INSURANCE
BI-WEEKLY RATES FOR ADDITIONAL INSURANCE

The County provides Group Term Life Insurance for all employees who are eligible for County benefits. Eligible employees may purchase additional insurance in $25,000 increments from the County's current insurance carrier, ReliaStar. Payroll deductions for additional life insurance are deducted bi-weekly.

All members may purchase up to $200,000.

COVERAGE	BI-WEEK RATE
$25,000	$3.20
$50,000	$6.39
$75,000	$9.59
$100,000	$12.78
$125,000 *	$15.98
$150,000 *	$19.17
$175,000 *	$22.37
$200,000 *	$25.56

***Evidence of Insurability Required for Amounts over $100,000 and any amount after 31 days from date of hire.**