



# ENROLLMENT AND ELECTION FORM

## January 1, 2022 to December 31, 2022

- New Hire   
  Cancel Dependent   
  Cancel Employee   
  Open Enrollment  
 Family Status Change   
  P/T to F/T Change   
  Reinstatement

Effective Date: \_\_\_\_\_

### SECTION A: Personal Information (Please print clearly)

Name (Last, First, MI):		Date of Hire:
Street Address:	Home Phone:	Social Security #:
City, State and Zip:	Work Phone:	Date of Birth:

### SECTION B: Employee/Dependent Information (Select Coverage)

Name (Last, First, MI)	Social Security Number	Date of Birth	Disabled?	Plan
Employee				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Spouse / Domestic Partner				<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Male    Dependent <input type="checkbox"/> Female			<input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Male    Dependent <input type="checkbox"/> Female			<input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Male    Dependent <input type="checkbox"/> Female			<input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Male    Dependent <input type="checkbox"/> Female			<input type="checkbox"/> Disabled	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

### SECTION C: Plan Information (Rates are based on 26 deductions per year)

Medical	Employee	Employee + One	Employee + Two or More
Kaiser Deductible HMO	<input type="checkbox"/> \$92.44	<input type="checkbox"/> \$216.19	<input type="checkbox"/> \$308.84
Kaiser Traditional HMO	<input type="checkbox"/> \$118.78	<input type="checkbox"/> \$260.06	<input type="checkbox"/> \$371.52

I am declining medical coverage (Please fill out Section G on back.)

Dental	Employee	Employee + One	Employee + Two or More
Guardian DHMO	<input type="checkbox"/> \$4.72	<input type="checkbox"/> \$9.03	<input type="checkbox"/> \$15.86
Guardian DPPO	<input type="checkbox"/> \$25.62	<input type="checkbox"/> \$50.64	<input type="checkbox"/> \$90.81

I am declining dental coverage (Please fill out Section G on back.)

Vision	Employee	Employee + One	Employee + Two or More
Guardian / VSP PPO	<input type="checkbox"/> \$4.19	<input type="checkbox"/> \$6.36	<input type="checkbox"/> \$11.18

I am declining vision coverage (Please fill out Section G on back.)

**\$15,000 Life insurance and \$15,000 AD&D insurance is provided for you by The Garland at no cost to you.**

**SECTION D: Plan Information**

PayPro Flexible Spending Accounts PayPro Flexible Spending Accounts	
Health Care Account Contributions up to IRS Maximum	\$ _____
Dependent Care Amount Contributions up to \$5,000 per year	\$ _____

**SECTION E: Other Insurance Coverage (If yes, please complete this section.)**

Medicare Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Subscriber:	Effective Date:
Name of Other Insurance Carrier:	Group Number:

**SECTION F: Employee Signature**

I elect coverage as indicated above and consent to all terms and conditions stated above. Furthermore, I declare that the information represented above is true and correct. If contributions are required for Group health plan coverage, I authorize my employer to deduct such contributions from earnings via payroll deduction until future notice. My participation in the plan is subject to all the plan terms and conditions as set forth in the plan documents and Summary Plan Description.

**SBC:** I hereby acknowledge receipt of the Summary of Benefits and Coverage (SBC). I have read the SBC and am familiar with its contents. If I have any questions concerning the information, I will contact the carrier or my Human Resource Department to have my questions answered. I understand this SBC is not a contract, and the material represents guidelines subject to change.

**Offer of Coverage:** I certify that I have received enrollment and plan information for health care coverage that The Garland offers, representing that it meets ACA requirements for affordable, minimum essential coverage, offering minimum value to me. I have been given the opportunity to enroll in or decline that coverage.

**Pre-Tax Payroll Deductions:** I authorize any payroll deductions required for the elections I have made above. I understand that these deductions will be made on a pre-tax basis unless I elect otherwise on this form. I understand that I cannot change my elections until the next open enrollment period, but I may change coverage for the dependents I am insuring or add new dependents if there is a "qualified" change in status. I have read the Summary Plan Description and understand the post-tax deduction option.

By checking this box I am declining the tax benefits I would receive under the Section 125 plan pre-tax option, and I understand that my deduction will be taken on a **post-tax basis**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Kaiser Foundation Health Plan, Inc., 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

\_\_\_\_\_  
Date

*\*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.*

**SECTION G: Declination of Coverage** Complete this section only if you do not want medical, dental or vision coverage

I decline coverage for:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
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Reason for declining coverage:	<input type="checkbox"/> Covered by another group health plan - attach proof of coverage <input type="checkbox"/> Covered by an individual health plan - attach proof of coverage <input type="checkbox"/> Other (e.g., Medicare, Champus, etc.) If you selected Other, please specify: _____ _____
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I understand that insurance coverages have been offered to me and my dependents by The Garland. I decline to participate in the plan at this time. I understand that if I decide to enroll at a later date, I will have to wait until the next Open Enrollment period unless I experience an allowable change event as defined by the Internal Revenue Code (IRC).

**Offer of Coverage:** I certify that I have received enrollment and plan information for health care coverage that The Garland offers, representing that it meets ACA requirements for affordable, minimum essential coverage, offering minimum value to me. I have been given the opportunity to enroll in or decline that coverage.

Signature: _____	Date: _____
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