(2017)

BERKELEY UNIFIED SCHOOL DISTRICT ANCILLARY ENROLLMENT/CHANGE FORM (INCLUDES FSA ELECTIONS)

Updated by: _____

Enrollment:	❑ New Enrollment	❑ Open Enrollment	❑ Change of Status		
Termination:	❑ All Plans	❑ Dental	❑ Vision		❑ Voluntary Life
Change:	❑ Add Dependent	❑ Add Newborn/Newly adopted child	❑ Change of Name	❑ Change of Address	Qualifying Event: _____
	❑ Loss of Other Coverage	❑ Remove Dependent	❑ COBRA	❑ Other (Please Specify) _____	Qualifying Event Date: _____

EFFECTIVE DATE	DENTAL GROUP NUMBER	SUBGROUP/ENROLLMENT UNIT

SECTION I – GENERAL INFORMATION

1. EMPLOYEE INFORMATION

LAST NAME (PRINT)	FIRST NAME (PRINT)	M.I.	☐ Male ☐ Female	TELEPHONE NO. ( )	DATE OF HIRE

STREET ADDRESS	CITY	STATE	ZIP

2. DENTAL & VISION ELECTION

DENTAL
☐ Delta Dental PPO ☐ Delta Care DMO Office Number ID Code (required): _____

VOLUNTARY VISION – Not Available for Retirees
☐ Vision Service Plan

3. EMPLOYEE & FAMILY INFORMATION – Please list yourself and all eligible members to be enrolled. (Attach additional sheet if necessary.)

	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	AGE	SOCIAL SECURITY	OTHER DENTAL OR VISION COVERAGE, IF APPLICABLE				TOTALLY DISABLED	PLEASE INDICATE A COVERAGE ELECTION FOR YOU AND YOUR DEPENDENTS.	
							Name of Other Carrier	Policy Holder Name and Address	Date of Birth	Effective Date		Dental	Vision
SELF											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter											☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. FLEXIBLE SPENDING ACCOUNT (FSA) ELECTIONS

I wish to contribute the following amount for the 1/1/17 – 12/31/17 Plan Year. My annual contribution will be deducted from my pay in equal amounts (10 pay-periods per year) and deposited into my Account(s). I understand that, once made, my elections are "irrevocable" during the plan year unless I experience a "qualifying and related change in status" or other permissible event as defined in the Plan and by the Internal Revenue code (IRS). I further understand that I must re-enroll for each new plan year during the District's annual open enrollment period. If I fail to do so, I may not participate until the District's next open enrollment period.

☐ **Health Care Spending Account ($2,550 annual maximum)** $_____ ☐ **Decline**

I understand that I will forfeit contributions that I have not claimed in excess of $500 from my medical FSA account after the end of each plan year. Any amount $500 or less will automatically be carried over to the new plan year and will be available to me even if I do not participate in the following plan year.

☐ **Dependent Care Spending Account* ($5,000 annual maximum)** $_____ ☐ **Decline**

I understand that I will forfeit contributions that I have not claimed from my Dependent Care FSA account after the end of each plan year. **Dollars do not rollover from year to year. Unused dollars are forfeited. (USE IT OR LOSE IT).**

*The maximum contribution is reduced if married filing separate return, spouse goes to school full-time, spouse is disabled, or spouse is expected to earn less than $5,000 in 2017 Plan Year.

5. LIFE INSURANCE – BENEFICIARY DESIGNATION

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from the District. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

***If you would like to apply for voluntary life insurance, please ask the Benefits Office for a separate form. An Evidence of Insurability form may be required.**

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo/Day/Yr)	Address (Street, City, State, Zip)	Benefit Percentage
Contingent Beneficiary Full Name (Last, First, Middle Initial)	**Relationship**	**Date of Birth (Mo/Day/Yr)**	**Address (Street, City, State, Zip)**	**Benefit Percentage**

6. PARKING & TRANSIT ELECTIONS

I understand the rules of IRC Section 132 allow me to use part of my salary on a pre-tax basis to purchase one or more of the following qualified benefits. I hereby elect to participate in my employer's Section 132 Parking & Transportation Plan as I have indicated below.

*** You are permitted to make a change or stop (meaning change to $0.00) your contributions to your Parking or Transit account elections on the first day of each month.**

** Active participants will have 5 days after the plan year ends to submit claims for expenses incurred by December 31, 2017. This is called your claims "run-out period". During the run-out period, any funds remaining in your prior year account(s) may only be used to pay for expenses incurred during the previous plan year. Once the run-out period ends, any unclaimed balance will be rolled-over to the new plan year and you may no longer be reimbursed for services rendered during the previous Plan Year.

Benefit	Participate?	Monthly Election
Parking Account – Maximum of $255 per month	☐ Yes ☐ No	$
Transit Account – Maximum of $255 per month	☐ Yes ☐ No	$
Debit Card Authorization – Check the appropriate box Do you want a debit card for the Parking & Transit Accounts?	☐ Yes – Please issue a card in my name ☐ No – I do not want a debit card	

7. AUTHORIZATION – SIGNATURE REQUIRED

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

EFFECTIVE DATE: The effective date of coverage is subject to carrier approval.

_____ _____
Employee Signature Date

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SECTION II – DOMESTIC PARTNER

DOMESTIC PARTNER NAME	SOCIAL SECURITY	DATE OF BIRTH	SEX ☐ Male ☐ Female	NAME AND ADDRESS OF EMPLOYER
ELIGIBLE DEPENDENT NAME	SOCIAL SECURITY	DATE OF BIRTH	Sex ☐ Male ☐ Female	NAME AND ADDRESS OF SCHOOL
ELIGIBLE DEPENDENT NAME	SOCIAL SECURITY	DATE OF BIRTH	Sex ☐ Male ☐ Female	NAME AND ADDRESS OF SCHOOL
ELIGIBLE DEPENDENT NAME	SOCIAL SECURITY	DATE OF BIRTH	Sex ☐ Male ☐ Female	NAME AND ADDRESS OF SCHOOL

DOMESTIC PARTNERSHIP POLICY AND DEFINITIONS

A Domestic Partnership shall exist between two persons regardless of their gender and each of them shall be the domestic partner of the other if both complete and sign this affidavit and attest to the following:

1. The two parties reside together share the common necessities of life.
2. The two parties are not married to anyone, not related to blood closer than would bar marriage in the State of California, and are mentally competent to consent to contract.
3. The two parties declare that they are each other's sole domestic partner and they are responsible for their common welfare.
4. The two parties agree to notify the Berkeley Unified School District Personnel Office if there is a change of the circumstances attested to in this affidavit.
5. All dependents under Domestic Partnership coverage shall have permanent residency in the Domestic Partnership household and shall meet all other dependent coverage criteria.
6. It has been at least six months since either of the two parties has filed a statement of termination of a previous domestic partnership affidavit with the appropriate District Personnel Office.

Domestic Partner/Same-Sex Spouse Taxation

The cost to cover a domestic partner/same-sex spouse and his or her dependent children is the same as the cost to cover all other eligible family members. However, employee contributions for domestic partners or same-sex spouses and/or their dependent children are made on an after-tax basis for federal tax purposes in compliance with Internal Revenue Service (IRS) regulations.

In addition, the cost of employer paid coverage for domestic partners or same-sex spouses and their children will result in taxable "imputed" income to the employee for federal tax purposes. This means the District's cost of the coverage is subject to federal income taxes as well as Federal Contributions Insurance Act (FICA). Imputed income will be reflected on the employee's paycheck and year-end W-2 form. The additional taxes will be withheld from pay.

I declare under penalty of perjury that all the foregoing information provided by me is true and correct and that all provisions of the Domestic Partnership eligibility and policy have been met.

Employee Signature _____ Date _____ Domestic Partner Signature _____ Date _____

Witness Signature, District Representative _____ Date _____

TERMINATION OF DOMESTIC PARTNERSHIP

I affirm, under penalty of perjury, that the Domestic Partnership Affidavit attested to and signed by me on _____ shall be and is terminated as of this date and that I shall cause notice of this termination by mailing via the United States Postal Service a copy of this signed Statement to my aforestated partner.

Employee Signature _____ Date _____

Witness Signature District Representative _____ Date _____

SECTION III – PAYMENTS OR TSA IN LIEU OF MEDICAL INSURANCE

I have received information on the various medical insurance providers available through Berkeley Unified School District. At this time, I elect to decline the medical coverage provided by the District for myself and/or my dependents listed below. I and/or my dependents are covered by another Health Plan. I understand that by declining this coverage, I am unable to enroll in the District's plan(s) until the next open enrollment period unless I experience an eligible qualifying event. I understand that if I or my dependents experience an eligible qualifying event, I have 30 days from the date of the event to notify the District and to request enrollment in the District's plan(s). Proof of the qualifying event must be provided to the District within 30 days of the event. If I notify the District after 30 days, I must wait until the next open enrollment period to make a change. I understand that the District is not responsible to cover any medical expenses that may arise while receiving cash in lieu.

I also understand that I will need to provide the District with adequate documentation to prove enrollment in the other medical plan. I will be required to substantiate my continued enrollment in other coverage each year during open enrollment.

Please list the name and number of the other medical plan.

Other Medical Plan's Name:_____ Medical Plan's Number:_____ Effective Date: _____

Please list all dependent(s) including spouse, covered under the plan listed above.

Spouse Covered:_____ * Do you currently have Medical Insurance with the District? _____

Dependents covered under plan:

Dependent Name #1 _____ Birth date _____ Dependent Name #2 _____ Birth date _____

Dependent Name #3 _____ Birth date _____ Dependent Name #4 _____ Birth date _____

Health Plan Card Verified ☐ Yes ☐ No

Employee Name _____ Signature _____ Date _____