Flexible Benefits Program Enrollment & Change Form
Plan Year 2022

Instructions: After completion, please return this form, along with any required back-up documentation, to your agency/department's Benefits Representative.

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email: Benefits.ServiceRep@ventura.org
Intranet: http://myvcweb/index.php/benefits
Internet: www.ventura.org/benefits

Type of Enrollment

- ☐ New Enrollment
- ☐ Mid-Year Change Request *(must also complete page 3 of this form)*
- ☐ Add Dependent/Date & Reason _____
- ☐ Cancel Dependent/Date & Reason _____
- ☐ Other _____

1. Employee Data (please print)

NAME (LAST, FIRST, M.I.)	EMPLOYEE ID NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (NUMBER & STREET)	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**WORK PHONE**	**GENDER (M/F)**	**HIRE DATE**
AGENCY/DEPARTMENT NAME	**BARGAINING UNIT**	**EMAIL ADDRESS**	

2. Medical Plan Coverage (pre-tax rates; see last page of this form for your biweekly flexible credit amount)

- ☐ Ventura County Health Care Plan HMO (EE only = $365.03/biweek, EE+1 = $634.89/biweek, EE + 2 or more = $810.24/biweek)
- ☐ Blue Shield Trio HMO (EE only = $352.81/biweek, EE+1 = $614.90/biweek, EE + 2 or more = $767.44/biweek)
- ☐ Blue Shield Access+ HMO (EE only = $417.58/biweek, EE+1 = $723.22/biweek, EE + 2 or more = $891.29/biweek)
- ☐ Blue Shield High-Deductible PPO (EE only = $459.72/biweek, EE+1 = $755.38/biweek, EE + 2 or more = $923.46/biweek)
- ☐ Medical Plan Opt-Out - Must submit Opt-Out Certification Form with proof of eligibility ($334.75/biweek)

3. Dental Plan Coverage (pre-tax tiered rates)

- ☐ MetLife Dental PPO (EE only = $21.07/biweek, EE + 1 = $40.16/biweek, EE + 2 or more = $60.73/biweek)

4. Vision Plan Coverage (pre-tax)

- ☐ MES Vision (EE only = $2.03/biweek, EE+1 = $3.66/biweek, EE + 2 or more = $5.24/biweek)

5. Flexible Spending Accounts (FSA pre-tax; annual re-election is required)

Health Care FSA (not available if enrolling in the High Deductible PPO):

- ☐ I elect a Health Care Flexible Spending Account with a semi-monthly pledge of $_____($10.00 - $114.58/semi-monthly).

Dependent Care FSA:

- ☐ I elect a Dependent Care Flexible Spending Account with a semi-monthly pledge of $_____($10.00 - $208.33/semi-monthly).

Limited-Purpose FSA (only available if enrolling in the Health Savings Account):

- ☐ I elect a Limited-Purpose Health Care Flexible Spending Account with a semi-monthly pledge of $_____($10.00 - $114.58/semi-monthly).

6. Health Savings Account (pre-tax; only available if enrolling in the High Deductible PPO)

- ☐ I elect a Health Savings Account with a semi-monthly pledge of $ _____

Individual Coverage – Maximum Biweekly Pledge is $152.08 semi-monthly ($193.74 if age 55 or older)

Family Coverage – Maximum Biweekly Pledge is $304.16 semi-monthly ($345.82 if age 55 or older)

7. Employee/Dependent Information (If enrolling in an HMO medical plan, please be sure to designate a primary care physician for yourself and your dependents. You may add additional dependents on a separate sheet of paper. Also, you must attach documentation that supports the relationship for each dependent; required documentation is listed on the following page.)

NAME (LAST, FIRST, M.I.)	RELATION-SHIP	DATE OF BIRTH	GENDER (M/F)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	PHYSICAN NAME (HMO only)	Previously seen?
Employee	**Self**	**See Page 1**			☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐

8. Signature

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I also understand and agree that:

- I have the website URL to the Flexible Benefits Program Benefit Plans Handbook, and I have read descriptions of benefits plans in which I am enrolling.
- My coverage elections on this form cannot be revoked or modified until the next open enrollment period, unless I have a qualifying change in status as defined by the IRS (see Benefit Plans Handbook, Chapter 1).
- I will verify that the enrollments and deductions I have authorized on this form have been implemented by reviewing my paystub for accuracy during the first pay period my selections are effective. I agree that failure to report an error within 30 days of the error's first appearance on my biweekly paystub is an affirmative election of the benefits listed on the paystub.
- I will notify the County immediately if I and/or my dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments.
- My pre-tax pay will be reduced by the amount of any required contributions noted for the coverage(s) elected after my flexible credits have been applied (flexible credit amounts are listed on page 3 of this form). My unspent flexible credits will be taxed and added to my paycheck as "Cash Back."
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I am enrolling.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s).
- A photocopy of this form is as valid as the original.
- If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.

Signature **Date**

WAIVER OF PARTICIPATION IN THE FLEXIBLE BENEFITS PROGRAM *(NOT THE SAME AS OPTING OUT OF MEDICAL COVERAGE; DO NOT SIGN IF YOU WISH TO OPT OUT)*

If you are eligible to participate in the Flexible Benefits Program but DO NOT WANT TO ENROLL, read this WAIVER OF BENEFITS and sign and date where indicated:

WAIVER OF BENEFITS: I have been informed about the County's Flexible Benefits Program. I understand that, if eligible, I am entitled to a Flexible Credit Allowance each pay period if I am enrolled in the Ventura County Flexible Benefits Program. I choose not to enroll and thereby waive and forfeit the County Flexible Credit Allowance. I understand that this decision is binding and that I will not have another opportunity to enroll until next annual Flexible Benefits Program open enrollment period.

Signature ***(DO NOT SIGN HERE IF YOU ARE ELECTING A PLAN OR OPTING OUT OF MEDICAL COVERAGE. THIS IS FOR WAIVERS ONLY.)*** Date

FOR OFFICE USE ONLY			
Department Authorization (Sign & Date)	HR/Benefits Authorization (Sign & Date)	Effective Date	Medical Plan Group ID #

☐ LTD Cert. Sent ☐ Life Ins. Cert. Sent ☐ COBRA Rights Sent (new spouse)

Flexible Benefits Program Mid-Plan Year Change Request Form

TO BE COMPLETED FOR MID-YEAR CHANGES ONLY
(not applicable for new employees' initial enrollment)

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email: Benefits.ServiceRep@ventura.org
Intranet: http://myvcweb/index.php/benefits
Internet: www.ventura.org/benefits

The Qualified Event Deadline will not be any later than (31) calendar days from the Qualified Event Date:

Qualified Event Date: _____

Qualified Event Deadline: _____

1. Employee Data (please print)

_____

NAME (LAST, FIRST, M.I.) **EMPLOYEE ID NUMBER**

2. Qualifying Mid-Year Event: _____

_____

3. Requested Plan Election Changes (please check all that apply)

Current Plan Year Elections	Requested Mid-Plan Year Elections
Medical Plan Coverage:	**Medical Plan Coverage**:
Dental Plan Coverage:	**Dental Plan Coverage:**
Vision Plan Coverage:	**Vision Plan Coverage**:
Health Care Flexible Spending Account:	**Health Care Flexible Spending Account**:
Dependent Care Flexible Spending Account:	**Dependent Care Flexible Spending Account**:
Limited-Purpose Flexible Spending Account:	**Limited-Purpose Flexible Spending Account:**
Health Savings Account:	**Health Savings Account:**

4. Employee Signature

The IRS has very specific rules governing when you may change your benefit elections and the required documentation that you should submit when cancelling or adding coverage. The change in your plan selections must be because of and consistent with the reason for the change and with the consequence that there is a gain or loss of coverage due to the change. Employees have 31 days from the date of the qualifying event to enroll, cancel or make changes to their benefit elections. Employees must notify the County immediately if they/or their dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments. In order to process a change, complete this form, attach the Enrollment and Change form and provide supporting documentation within 31 days of the qualifying event. I understand if I miss the deadline, I must wait until open enrollment to make changes to my benefits.

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable.

Signature **Date**

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Department Authorization (Sign & Date)	HR/Benefits Authorization (Sign & Date)	Effective Date	Medical Plan Group ID #

PY 2022 – Revised 02/04/2022

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
SPOUSE Your current legal husband or wife	• Copy of page 1 of your most-recently filed federal tax return (as filed) listing spouse (financial data may be blacked out), OR • Copy of official marriage certificate
REGISTERED DOMESTIC PARTNER Your domestic partner who is registered with you through the State of California or any other California County or Municipality's domestic partner registry	• Copy of Declaration of Domestic Partnership (as filed with the official domestic partner registry), AND • Proof relationship is still current (a copy of a utility bill with your registered domestic partner's name on it that is mailed to your home on a regular basis and dated within the past 60 days.)
CHILD* under the age of 26 Your child under the age of 26 (certain unmarried children, if handicapped prior to age 19 and continuously covered by a County-sponsored medical plan since prior to age 19, and incapable of self-support may be eligible beyond age 26, if proper documentation of disability is submitted)	One of the following: • Copy of page 1 of your most-recently filed federal tax return (as filed) listing child as dependent, OR • Copy of birth/adoption certificate or Qualified Medical Child Support Order. AND • Current residence and mailing address, if different than employee

* The basic definition of "child" is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse or registered domestic partner, or both.

*In the event of a discrepancy between what is stated on this form and what is stated in the County of Ventura's Benefit Plans Handbook, the information indicated in the Benefit Plans Handbook shall be the deciding authority.

Most birth certificates and marriage certificates can be ordered online at www.vitalchek.com, if you don't already have a copy. For copies of court documents such as adoption or custody proceedings, you can contact the Clerk of Court's office where the proceedings took place. Any costs you may incur to obtain your documents will be at your expense.

If you are unable to obtain any of the required documents, please contact County Benefits *as soon as possible* to determine if there are acceptable alternatives.