Flexible Benefits Program Enrollment & Change Form

Plan Year 2025

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 = $412.59/biweek, EE+1 = $824.26/biweek, EE + 2 or more = $1,071.26/biweek)
- ☐ Blue Shield Trio HMO (EE only = $344.18/biweek, EE+1 = $687.45/biweek, EE + 2 or more = $893.40/biweek)
- ☐ Blue Shield Access+ HMO (EE only = $440.66/biweek, EE+1 = $880.40/biweek, EE + 2 or more = $1,044.25/biweek)
- ☐ Blue Shield High-Deductible PPO (EE only = $532.25/biweek, EE+1 = $984.40/biweek, EE + 2 or more = $1,279.03/biweek)
- ☐ Medical Plan Opt-Out - Must submit Opt-Out Certification Form with proof of eligibility (Opt-Out Allowance dollar amounts vary by bargaining agreement. See page four of this form for Opt-Out Allowance biweek amounts.)

OR***DO NOT COMPLETE BELOW UNLESS YOU ARE WAIVING ENROLLMENT IN THE COUNY'S FLEXIBLE BENEFIT PROGRAM**

☐ **Waiver of Participation in the Flexible Benefits Program** (**Not the same as Opting Out**) ($0.00 prem or Flex Credits provided /biweek) Caution: By checking this box, initialing, and dating at the end of this paragraph, and signing and dating page two of this form, you confirm you've been informed about the County's Flexible Benefits Program. Furthermore, you understand that, if eligible, you are entitled to a Flexible Credit Allowance or Opt-Out Allowance each pay period if you were to enroll in the Ventura County Flexible Benefits Program by electing at least one of the Medical Plans or Medical Opt-Out Plan above. You choose not to enroll, waiving and forfeiting the County Flexible Credit Allowance/Opt-Out Allowance. You also understand that this decision is binding and that you will not have another opportunity to enroll until the next annual Flexible Benefits Program open enrollment period.
Initial_____ Date_____ here only if you wish to Waive participation in the Flexible Benefits Program.
(You cannot elect any other plans on this form if you elect this option.)

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

- ☐ MetLife Dental PPO (EE only = $22.22/biweek, EE + 1 = $42.35/biweek, EE + 2 or more = $64.04/biweek)

4. Vision Plan Coverage (pre-tax)

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

5. 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 $179.16 semi-monthly ($220.83 if age 55 or older)

Family Coverage - Maximum Biweekly Pledge is $356.25 semi-monthly (397.91 if age 55 or oder)

6. 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 $_____($1.00 - $133.33/semi-monthly).

Dependent Care FSA:

☐ I elect a Dependent Care Flexible Spending Account with a semi-monthly pledge of $_____($1.00 - $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 $_____($1.00 - $133.33/semi-monthly).

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 4 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.
- If you initialed and dated on page one, section one, to waive participation in the County's Flexible Benefits Program, you are signing below acknowledging that election. You will not receive any Flexible Credit/Opt-Out Allowance from the County. You will be unable to enroll in any of the Flexible Benefits Program's plans, for any reason, until the next open enrollment period.

Signature **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 Equity Health Savings Account:	**Health Equity Health Savings Account:**

4. Employee Signature

All life events and mid-year changes must be submitted within 31 days, including the date of the event, except for gain or loss of dependents coverage under Medi-Cal, Medicaid, or CHIP programs, which is 60 days. To process a change, complete and return the Mid-Year Change Request page of this form (including sign and date) and the Enrollment and Change section of this form where applicable (including sign and date) within 31 days of the qualifying event (including the life event/effective date of the event that warrants the change request). The forms must be received within 60 days, even if supporting documentation is not yet available. The event date, which starts the period to request a change, is the effective date of coverage gain or loss, or the event date in the case of (marriage, birth, adoptions, etc.).

The IRS has specific rules governing when an employee may make a change to benefit elections. Therefore, we must receive the required supporting documentation when canceling or adding coverage. The change in 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 60 days, including 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. If ineligibility is determined, I understand and agree that coverage will be terminated retroactively 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. I understand that if I miss the deadline, I must wait until the next open enrollment to make any 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 the 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**

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

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 26 and continuously covered by a County-sponsored medical plan since prior to age 26, 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, 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 guardianship 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.

Opt-Out Allowance Bi-weekly amounts provided per bargaining agreement for employees with a work schedule of 60 or more hours per pay period. Part-time employees working less than 60 hours per pay period are not eligible for the Opt-Out Allowance. **Courts employees have not opted into the Opt-Out Allowance and are still receiving the full flex credit and are charged the Opt-Out Fee.

CNA & VEA $303.43
CJAAVC $209.00
VCDSA $229.94
VCPFA $191.78
VCPPOA Probation Unit $236.00
VCPPOA Patrol Unit $145.00
SPOAVC $147.00
VCSCOA $140.00
APCD, IUOE, MGMT, SEIU, UAPD $150.00