DELTA DENTAL®

Benefit Enrollment & Change Form

DDC/DDIC Management Employees

Section I — Personal Information

Please complete, sign, and date form, and return to your local Human Resources Department. List yourself and all eligible family members to be enrolled. If you are adding a new dependent you must include documentation as described in the Acceptable Proof for Adding a Dependent document found on the employee intranet on the benefits forms page.

The Delta Dental of California Employee Health & Welfare Benefits Plan

Employee Name: Last, First, MI	Employee ID	Social Security Number
Atkinson Mark H.	CA34081	
Change Name To: Last, First, MI	Employee Gender ☒ Male ☐ Female	Home Phone

Street Address	City	State	ZIP
757 Elm Drive	petaluma	CA	94952

Status: ☐ Single ☐ Married ☐ Domestic Partnership	Date of Hire: Month, Day, Year	Date of Birth: Month, Day, Year

Section II — Life Event Information

Life Event Date:

Type:

- ☐ A. New Enrollment
- ☐ B. Open Enrollment
- ☐ C. Reinstatement
- ☐ D. Add Dependent
- ☒ E. Remove Dependent
- ☐ F. Name/Address Change
- ☐ G. Other:_____

Reason:

- ☐ A. Marriage
- ☐ B. Divorce
- ☐ C. Domestic Partner Add
- ☐ D. Death
- ☐ E. Domestic Partner Deletion
- ☐ F. Birth or Adoption
- ☒ G. Gain/Loss Spouse Coverage
- ☐ H. Other:_____

For COBRA enrollees provide address of your dependent if different:

Section III — Plan Information

If applicable, employees and their dependents will be enrolled in medical, prescription, dental, and vision by completing this form.

Medical/Prescription

- ☒ A. Anthem Blue Cross PPO/Caremark
- ☐ B. Anthem Blue Cross CDHP/Caremark
- ☐ C. Kaiser Permanente HMO/Kaiser

Medical	Tier
☐ Add	☐ EE only
☐ Change	☐ EE + 1
☒ Waive	☐ Family
☐ Delete	

Dental

- ☐ A. Delta Dental PPO℠
- ☐ B. DeltaCare® USA

Dental	Tier
☐ Add	☐ EE only
☐ Change	☐ EE + 1
☐ Waive	☐ Family
☐ Delete	

Vision

☐ VSP

Vision	Tier
☐ Add	☐ EE only
☐ Change	☐ EE + 1
☐ Waive	☐ Family
☐ Delete	

Health Savings Account (HSA) and Flexible Spending Accounts (FSA)

Pre-tax election to help you lower your taxable income while paying for health plan out-of-pocket expenses. Enter your annual goal amount. Biweekly payroll deductions will be taken out of 24 paychecks annually (no deductions from the 3rd check of a month)

	Health Savings Account (HSA)	Limited Purpose Flexible Spending Account (LP FSA)	Health Care Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account (FSA)
Medical Plan Requirement	for CDHP Enrollees Only	for CDHP Enrollees Only	No Medical Plan Enrollment Required	No Medical Plan Enrollment Required
Annual Limit	$3,450/Individual Coverage $6,900/Family Coverage	$2,650/maximum contribution/$200 minimum contribution	$2,650/maximum contribution/$200 minimum contribution	$5,000/maximum contribution/$100 minimum contribution
Annual Delta Dental Contribution	$500/Individual Coverage $1,000/Family Coverage	No Employer Contribution	No Employer Contribution	No Employer Contribution
Catch-up over age 55	$1,000	N/A	N/A	N/A
Your Elected Annual Goal Amount	$_____	$_____	$_____	$_____

Section IV — Dependent Information

If you are adding or removing coverage for your eligible dependents, you must complete this section. If additional space is needed, please attach a separate page.

	Name: Last, First, MI	SSN	DOB		
☒ Spouse ☐ Domestic Partner	Atkinson Deborah A		12/23/1953	☐ Add ☒ Remove	Gender ☐ Male ☒ Female
☐ Son ☐ Daughter				☐ Add ☐ Remove	Age 26 or older ☐ Disabled

Section V — Waiver of Coverage

Complete if applicable. Medical is the only waiver

I am waiving (please circle all that apply) Medical, Dental, and/or Vision coverage for:

- ☐ Myself, my spouse/domestic partner and all my dependents
- ☒ My spouse/domestic partner only
- ☐ The following dependents:_____

Reason for waiving coverage (please check one box only)
The individuals waiving coverage have:

- ☐ Another employer health benefit plan
- ☒ Individual plan through separate carrier

If you are waiving medical coverage for your spouse or domestic partner in Section 5 above, you may be eligible to receive an annual opt-out payment of up to $1,200. To receive the annual payment, you must provide Human Resources with an Election of Spouse/Domestic Partner Opt-Out Form, and all required documentation.

Section VI — Supplemental Life Insurance

Delta Dental automatically provides you with Basic Life and AD&D Insurance. Management employees may purchase additional coverage for themselves and their dependents. If you are interested in purchasing additional insurance, please check the box below and you will be contacted by Human Resources. For more details regarding the amount of supplemental life insurance that is available to you, please review the Life Insurance section of the Summary Plan Description which can be found on the Human Resources pages of the employee intranet.

- ☐ I am interested in purchasing supplemental insurance
- ☐ I am interested in purchasing supplemental AD&D insurance

Section VII — Employee Authorization

I have read and understand the provisions outlined on this form and assert all information on this form is correct and true. I am entitled to a copy of this signed authorization for my files. By signing this document, I am accepting all terms and conditions located on the back of this document.

Employee Signature: Mark H. Atkinson **Date:** 12/21/2018

For Human Resources Use Only

Effective Date of Coverage: _____/_____/_____ **Processing Date:** _____/_____/_____ **Processed By:**

Delta Dental of California and Entities
Authorizations and Disclosures

Deduction Authorization: I authorize my employer to deduct from my wages the required contribution amount if applicable, based on my elections. I understand that contributions will be deducted on a pre-tax basis unless I request otherwise.

Non-Participating Provider: I understand that I am responsible for a greater portion of my medical, dental and vison costs when I use a non-participating provider.

Authorization to Obtain or Release Medical Information: I authorize my physician, dentist, or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Anthem Blue Cross, Kaiser Foundation Health Plan and/or CVSCaremark its agents, employees, designee, or representatives, including my Anthem Blue Cross, Kaiser Foundation Health Plan and/or CVSCaremark agent or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given me or any of my dependents applying for or having Anthem Blue Cross, Kaiser Foundation Health Plan and/or CVSCaremark coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any application for coverage or any claim for benefits.

I also authorize Anthem Blue Cross, Kaiser Foundation Health Plan and/or CVSCaremark to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits. If my coverage is under a Group Master Policy held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure of them for the purpose of administering my coverage, utilization review or financial audit.

This authorization is effective on the date medical plan coverage takes effect and shall remain in effect for as long as the employee is a member of an Anthem Blue Cross medical plan or Kaiser Foundation Health Plan and/or CVSCaremark prescription plan. A photocopy of this authorization is as valid as the original, and I and my Anthem Blue Cross, Kaiser Foundation Health Plan and/or CVSCaremark agent or broker are entitled to receive a copy of this form.

Refusal of Personal Coverage: I understand that if I decline coverage for myself and my dependent(s), my next opportunity to enroll in the benefits plan will not be until the company's next annual open enrollment period. However if I experience a qualified family status change during the year I may request to change my benefit elections in my employer's health plan by applying for that coverage within 31 days of the qualified family status change.

Effective Date: The effective date of coverage is the first of the month following the date the election change is requested.

Kaiser Foundation Health Plan 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 Kaiser Permanente Plan **Date**