SANTA ROSA JUNIOR COLLEGE

2018 RETIREE OPEN ENROLLMENT

The month of August is the Open Enrollment period for the District's retiree medical plans. This year is also the dental open enrollment year, which happens every three years. If you would like to switch your medical coverage from one plan to another, or add eligible dependents to your medical coverage, August is the time to complete the required forms.

The renewal rates listed below will become effective October 1, 2018, and will remain in place through September 30, 2019.

SENIOR ADVANTAGE

Single Kaiser Sr. Advantage	(1) over 65	$ 374.00
Double Kaiser Sr. Advantage	(2) over 65	$ 748.00
Double Kaiser Sr. Advantage	(1) over 65 + (1) under 65	$ 1,000.00

COMPANION CARE

Single Companion Care	(1) over 65	$ 386.00
Double Companion Care	(2) over 65	$ 772.00
Double Companion Care	(1) over 65 + (1) under 65	$1,163.00

SRJC RETIREE DENTAL

Single	(1)	$ 84.00
Double	(2)	$ 169.00
Family	(3) or more	$ 235.85

- If you would like to continue with your current coverage, there is no action needed on your part!
- If you would like to make a change to your medical coverage, you must complete a change form. Enrollment/change forms are available on the following page.

2018 MEDICAL PLAN SUMMARIES OF BENEFITS

The Summaries of Benefits listed on this page are provided for comparison purposes.

Membership Change form

SISC/KAISER SENIOR ADVANTAGE

Kaiser Senior Advantage

Kaiser Senior Advantage Enrollment Form

SISC/COMPANION CARE

Companion Care - Medicare Supplement Plan Summary

Companion Care Enrollment Form

Prescription Drug plan with this plan is through Navitus

Additional Benefits

Blue Shield Silver and Fit

Kaiser Silver and Fit

For the Dental Membership Change form, please see the next page:

EMPLOYEE ENROLLMENT/CHANGE FORM

Use this form for a new enrollment or a change to an existing enrollment for Dental Coverages. Mail to: Arrow Benefits Group, P.O. Box 750578, Petaluma, CA 94975 or fax to: 707-544-1804 or email to: DanielleR@arrowbenefitsgroup.com

Group Number: 804 - Santa Rosa Junior College **Effective Date of Enrollment/Change**: _____

Enroll for Dental Coverage	**Additional Notes**
☐ Yes ☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family	
☐ No, I do not want this coverage for the following reason(s): *Check all that apply* ☐ I do not need dental coverage. ☐ I am covered under another Dental plan. ☐ My spouse/domestic partner is covered under another Dental plan. ☐ My dependents are covered under another Dental plan.	

Reason for Enrollment / Change

☐ New Enrollment/New Hire
- ☐ Qualifying Event *(Attach supporting documentation)*
- ☐ Late Enrollee

☐ Add Dependent
Qualifying Event: _____
Date of Qualifying Event: _____

☐ Change of Address

☐ Terminate Coverage:
- ☐ Subscriber Only ☐ Dependent(s) Only
- ☐ Subscriber & Dependents

☐ Change in Other Insurance

☐ Other (*Please Specify):*
_____

Subscriber (Employee) Information

Social Security Number: _____ Date of Hire: _____

Last Name: _____ First Name: _____MI: _____

Street Address:_____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ E-mail Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Non-binary

Employer (Company) Name:_____

Job Title: _____Division/Class: _____ Hours Worked Per Week:_____

Preferred Spoken Language: _____ Preferred Written Language: _____

Are you married or do you have a spouse/domestic partner? ☐ Yes ☐ No Date of marriage/union: _____ - _____ - _____

Do you have children or other dependents? ☐ Yes ☐ No Placement date of adopted child(ren): _____ - _____ - _____

_____ - _____ - _____

Dependent Information:

- *New Enrollment/New Hire: Complete this section for all dependents you are choosing to enroll.*
- *Coverage Type options limited to the Coverage Type(s) elected by the Subscriber.*
- *Add Dependent: Complete this section only for the dependents you are adding to your existing enrollment.*
- *Terminate Dependent Coverage: Complete this section only for dependent(s) you are choosing to terminate.*

Relation to Subscriber		Last Name	First Name & MI	Date of Birth	Sex (M/F/NB)	Other Dental Insurance Carrier
Spouse or Registered Domestic Partner	☐ ADD ☐ DROP					
Child	☐ ADD ☐ DROP					
Child	☐ ADD ☐ DROP					
Child	☐ ADD ☐ DROP					
Child	☐ ADD ☐ DROP					
Child	☐ ADD ☐ DROP					

A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents. Supporting documentation of dependent eligible status must be submitted with this form for dependent children over the Plan's specified age limit for the enrollment to be processed and claims paid.

To the best of my knowledge and belief, I have answered truthfully and completely the information requested on this application. I understand that Arrow Benefits Group reserves the right to rescind or terminate coverage if any material misrepresentation is made in this form.

SIGNATURE:

- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable plan document.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined by my employer.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please contact Arrow Benefits Group.
- Your coverage will not be effective until approved by Arrow or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Employee Signature: _____ **Date**: _____

I, on my behalf and on behalf of my dependent(s) on this enrollment application, hereby (1) request coverage for the group insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for the insurance, or agree that the contributions be added to my dues; (3) state that I became a full-time employee on the date stated on the reverse, and do currently work the number of hours per week stated on the reverse, (4) agree to be bound by benefits, copayments, deductibles, exclusions, limitations, and other terms and conditions of the Arrow* Certificate of Insurance, (5) agree that if I or my dependents receive services after my coverage is terminated or lapses, that I am responsible to reimburse Arrow for any unrecovered payments made by Arrow for such services, and (6) understand that verification of eligibility by Arrow does not guarantee payment of claims and that retroactive eligibility changes supersede verifications of eligibility.

DENTAL AND RELEASE: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby authorize Arrow to release dental and information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Arrow. If you request, Arrow will provide a copy to you of any information it discloses to third parties regarding your dental information. This Dental Release authorization shall remain in effect thirty months from the date the application is signed. This Dental Release authorization solely provides authorization of Arrow to release dental information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain dental information to or from other appropriate agencies and providers for the provision of necessary dental services and supplies covered by Arrow. The dental information is being collected by Arrow solely for the specific purpose of premium underwriting.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Arrow are the primary financial responsibility of another party, because of other dental coverage, I will inform Arrow and will execute such assignments, liens or other documents which may be necessary to enable Arrow to recover the value of services and supplies provided.

** All references to "Arrow" herein refer to Arrow Benefits Group*

Arrow Benefits Group