



HEALTH BENEFITS ENROLLMENT FORM

CAFETERIA WORKERS

DO NOT COMPLETE SHADED AREAS

PLEASE PRINT LEGIBLY

EMPLOYEE NUMBER	LAST NAME	FIRST NAME		MI
ADDRESS (STREET)		CITY	STATE	ZIP
				PHONE NUMBER
BIRTH DATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SOCIAL SECURITY NUMBER	

EFFECTIVE DATE	INITIALS	DATE PROCESSED	BARGAINING UNIT
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I HAVE REVIEWED THE HEALTH PLAN OPTIONS AVAILABLE. PLEASE ENROLL ME IN THE PLAN(S) CHECKED BELOW.
 Coverage under the District's health care and life insurance plans begin the first day of the month following the date your properly completed Enrollment Form is received by the Health Benefits Administration, provided you are actively at work.

CHECK (/) ONLY ONE		PLAN NAME
	Plan Code	MEDICAL
	53	Health Net HMO (Cafeteria)
	70	Medical Opt-Out Cash Back Plan
		DENTAL
	88	Western Dental DHMO
		VISION
	91	EyeMed Vision Care
		LIFE
	20	District Basic Plan Only

BENEFICIARY - The following order of payment will determine the persons to receive the benefits.
 (1) Surviving wife or husband of the insured employee; (2) Surviving children of the insured employee in equal shares; otherwise, (3) Surviving parent(s) of the insured employee in equal shares; otherwise, (4). The estate of the insured.

The beneficiary for dependent coverage and spouse coverage shall be the employee or his/her estate.

If you want to designate a beneficiary for the employee coverage other than as shown above, please contact MetLife Insurance Company at (866) 492-6983.
 SEE OPTIONAL SUPPLEMENTAL LIFE BROCHURE for payroll deducted optional life insurance.

DEPENDENTS

ELIGIBLE FAMILY MEMBERS TO BE ENROLLED IN PLANS (SEE REVERSE SIDE FOR INSTRUCTIONS)

SSN	LAST NAME	FIRST NAME	MI	RELATIONSHIP	DATE OF BIRTH	EFF. DATE

Social Security Number is mandatory for all dependents. Newborn child: Social Security Number is required within 2 months.

Is your spouse/Domestic Partner a LAUSD employee? Yes No Employee # _____

NO DUAL COVERAGE ALLOWED. SEE REVERSE SIDE FOR ELIGIBILITY RULES.

I understand this election will remain in effect so long as I remain eligible, or until I make another election during an annual enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plans elected. I understand that it is my responsibility to report any change in the eligibility of my dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

SIGN HERE	APPLICANT'S SIGNATURE:	DATE:

INSTRUCTIONS

In order to assist the District in ensuring that your eligible dependents are properly enrolled under your District-sponsored plan, please read and follow the instructions below.

- Complete this form, being sure to list **all** dependents you wish to have added. If necessary, attach an additional sheet of paper to the form.
 - a. List birthdays and Social Security numbers for all dependents. Social Security numbers are mandatory. Social Security numbers for newborns must be provided within two (2) months.
 - b. If your spouse/domestic partner is also a District employee, please list his or her employee number. **If you both enroll in the same plan(s), you may not cover each other as dependents; similarly, only one of you may cover your eligible children under the plan(s).**
- Provide verification of dependent status for dependents as follows:
 - a. Spouse - attach a copy of your marriage certificate issued by the state.
 - b. Domestic Partner - complete Declaration of Domestic Partnership form (available from the Health Benefits Administration) and submit the required documentation as outlined in Section II of the Declaration form or submit a copy of your registration with the State.
 - c. Natural children - attach a copy of official birth certificate for each child. Complimentary hospital certificates will be accepted for newborns only. After a child is 5 months, an official birth certificate is required.
 - d. Stepchildren - for each child, attach a copy of the birth certificate and a copy of your marriage certificate (issued by the state).
 - e. Adopted children - attach a copy of the document verifying legal custody.
 - f. If your eligible dependent is age 19 but under age 25, you will also need to provide verification of his/her full-time (8 units) student status. Verification of enrollment must include: student's name, name of school, semester enrolled and number of enrolled units. An official letter from the school verifying your child's full time status is also acceptable.
 - g. If you are the legal guardian of a child, please attach a copy of the guardianship papers issued by the court.
 - h. Disabled dependent - must meet the disability standards of the plan and must be enrolled prior to age 19.

NOTE: Retirees Only - To continue your benefits, you must complete an "Application for Continuation of Health Benefits" (HI-22) and submit it along with a copy of your "Notice of Benefit Approval" (PERS) or "Award Letter" (STRS) to Benefits Administration.

EFFECTIVE DATE OF ADDITIONS:

Coverage will begin on the first day of the month following the receipt of the Health Benefits Enrollment form along with the required verification. **Example:** If verification and Health Benefits Enrollment form is received by Benefits Administration on January 1st, the dependent's eligibility becomes effective February 1st.

Spouse/Children

Newborns: If you submit verification of birth (complimentary hospital birth certificate is acceptable) within 30 days of birth, the newborn will be covered back to date of birth. If submitted more than 30 days but less than 5 months, the newborn will be covered on the first of the month after the verification was received. After 5 months, an official birth certificate is required.

Guardianship/Adoption: If you submit verification of guardianship/adoption within 30 days of the guardianship/adoption, coverage will begin on the date of guardianship/adoption. If submitted more than 30 days, coverage will begin on the first of the month after the verification was received.

Spouse: An official marriage certificate is required. However, if received within 30 days of the marriage date, spouse will be covered effective the date of the marriage.

Domestic Partners: If all of the required documentation is received by Benefits Administration by the 10th of the month, coverage will be effective the first of the following month.

DEPENDENTS FOR WHOM THE REQUIRED DOCUMENTATION IS NOT RECEIVED WILL NOT BE COVERED UNDER YOUR MEDICAL, DENTAL OR VISION PLAN(S) UNTIL THE APPROPRIATE DOCUMENTATION IS RECEIVED.

TERMINATION OF COVERAGE:

Coverage will be terminated on the last day of the month in which the dependent became ineligible.

- Complete and return this form along with copies of the required documents to:

Los Angeles Unified School District
Health Benefits Administration
P.O. Box 513307 Los Angeles, CA 90051-1307

If you have any questions, please call the Health Benefits Administration at (213) 241-4262.