CITY OF
LONG BEACH

BENEFITS SELECTION FORM

Please refer to the Employee Benefits Overview booklet for plan options and employee contribution rates.
*Complete the **entire** form and attach any necessary documentation before submitting to your department PPA.*

EMPLOYEE INFORMATION:

Legal Name (First, MI, Last): ____________________ **SSN:** ____________

Employment Status: PF (Full-Time) ☐ PP (Part-Time) ☐ SP (Seasonal Part-Time) ☐

Marital Status: Single ☐ Married ☐ **Does spouse/RDP work for the City of Long Beach:** No ☐ Yes ☐
Name: Department:

TYPE OF ACTION: (Check One)

Qualifying Event Date: ____________ **Coverage Effective Date:** ____________

New Hire ☐ Open Enrollment ☐ Marriage ☐ Divorce ☐ Birth/Adoption ☐ Death ☐
Add/Delete Dependent(s) ☐ Waive/Cancel ☐ Other ☐ (please explain) ____________

Enrollment :
Anthem PPO ☐ Anthem HMO ☐
Delta PPO ☐ Delta HMO ☐
Vision ☐

Waive/Cancel:
Health ☐
Dental ☐
Vision ☐

Annual FSA Amount ($100 minimum per acct):
FSA Health $_________ ($2,650 maximum)
FSA Dependent $_________ ($5,000 maximum)
(FSA Plan Year is January 1 - December 31)

DEPENDENT INFORMATION

Name (First, M.I., Last)	Relationship*	Gender	Date of Birth	SSN	Add/Delete

Relationship Codes: SP-Spouse DP-Domestic Partner NC-Natural Child SC-Step Child AC-Adopted Child GC-Guardian Child

Required Verification for Dependents - Include copies of the following, if applicable:

Spouse: Marriage Certificate ☐ Divorce Decree ☐ *(Marital status and date must be updated in the system)*
Registered Domestic Partner: Declaration of Domestic Partnership ☐ Dissolution of Domestic Partnership ☐
Dependent Child: Birth Certificate ☐ Adoption Certificate ☐ Qualified Medical Child Support Order ☐

I acknowledge that the above information represents my enrollment choice(s). I understand that by signing this form I am electing to reduce my compensation in exchange for pre-tax health care coverage and I authorize payroll deductions for any required contribution. I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. If applicable, I hereby authorize any insurance company, hospital, physician or any other health care provider to release all information to all those who may have a bearing on benefits payable under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions identified above by the City's Coding System, provided that the method, manner and amount of each such adjustment is in full compliance with the applicable laws or administrative rules and regulations of the City.

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that it is exempt from ERISA or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision: If you are applying for coverage, please note that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company require binding arbitration to settle all disputes including but not limited to disputes relating to the delivery of service under the plan/policy or any other issues related to the plan/policy and claims of medical malpractice, if the amount in dispute exceeds the jurisdictional limit of small claims court. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. This means that you and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company are waiving the right to a jury trial for both medical malpractice claims, and any other disputes including disputes relating to the delivery of service under the plan/policy or any other issues related to the plan/policy.

Employee Signature: ______________________ **Date:** ____________

For Department Use Only:
If the Qualifying Event was a marital status update (marriage or divorce), PPA must update the City's electronic system of record (initial here):________
Department:____________ PPA Name (Print):____________________ Extension:__________