Bay Area Rapid Transit

HEALTH BENEFITS FORM

Employee Name: ______________________________ Employee Number: ______________

Instructions: Select from each category. If you fail to make a selection and/or meet the 30 or 60-day time period, a 90-day waiting period occurs with coverage beginning first of the month after the waiting period ends.

Section A: Medical – Use **ONLY** if you are a first-time enrollee, changing plans, or canceling.

Medical Insurance: Submit within 60 days from the qualifying event date.
Domestic Partner Insurance: Submit within 30 days from the qualifying event date.

* Request to change plans due to address change must be received within 60 days after changing home address in Employee Connect Self Service

Plan eligibility is based on zip code. Go to www.calpers.ca.gov to find the plans in your zip code.

Section B: Dental and Vision – *Use **ONLY** if you are a first-time enrollee, changing plans or canceling.*

Dental and Vision Insurance: Submit within 30 days from the qualifying event date.

Plan (Select a vision and / or dental plan)

** Vision Plan changes (basic to enhanced or vice versa) can only be made during Open Enrollment in even numbered calendar year (e.g., 2024, 2026 etc.)
** Dental Plan enrollment or cancellation for Part-Time ATU can be done only during Open Enrollment in even numbered calendar year

Section C: Enroll Dependents – *Select all that apply.*

Provide supporting documentation. (See attached list)

- ☐ Adoption / Newborn
- ☐ Dependent Lost Coverage
- ☐ Marriage
- ☐ Court Order
- ☐ Domestic Partner Adult or Child
- ☐ Open Enrollment
- ☐ Custody Change
- ☐ First Transit Pass (age 5 and older)
- ☐ Parent-Child Relationship

Section D: Remove Dependents – *Select all that apply.*

Provide supporting documentation. (See attached list)

- ☐ Custody Change
- ☐ Divorce
- ☐ Open Enrollment
- ☐ Death of Dependent
- ☐ Domestic Partnership Ends
- ☐ Parent-Child Relationship Ends
- ☐ Dependent Moves Out
- ☐ Gains Other Coverage

Supporting Documentation – *A copy of the following must be provided before coverage begins or ends.*

- CalPERS Affidavit of Parent-Child Relationship — ***Enroll –*** *Grandchildren, nieces, nephews or cousins.*
- County Birth Certificate — ***Enroll –*** *All children*
- County Marriage Certificate — ***Enroll –*** *Spouse*
- Court Document — ***Enroll –*** *Adoption, foster care, custody change or court order*
- Declaration of Domestic Partnership — ***Enroll –*** *State of California registered domestic partner*
- Domestic Partner Affidavit of Eligibility — ***Enroll –*** *Non-registered domestic partner*
- Loss of Coverage Document — ***Enroll –*** *Qualifying event is loss of coverage.*
- Social Security Number — ***Enroll –*** *Any dependent*

- County Death Certificate — ***Remove –*** *Deceased spouse or child*
- Entire Divorce Decree — ***Remove –*** *Former spouse or step-children*
- Mailing Address of former spouse — ***Remove –*** *Former spouse or step-children. Required for COBRA.*
- Notice of Termination of Domestic Partnership — ***Remove –*** *Former State of California registered domestic partner*
- Proof of Other Coverage — ***Remove / Cancel –*** *Gains other coverage / cancels*

Enroll / Remove Dependents – *Print the dependent's legal name, date of birth, relationship and social security number.* ***Effective Date section is for Office Use Only.***

	Dependent #1	Dependent #2	Dependent #3	Dependent #4
Name: (First, Middle, Last)				
Date of Birth:				
Relationship:				
National ID (SSN)				
Medical				
Vision				
Dental				
Transit Pass (Age 5 or older)				

Flexible Spending Account Changes

- The **Health Care Reimbursement** account allows the use of pre-tax dollars to pay for out-of-pocket health care expenses such as deductibles, co-insurance, co-pays ,prescriptions and other related qualifying expenses.
- The **Dependent Care Reimbursement** account allows reimbursement with pre-tax dollars of qualifying expenses related to childcare, pre-school, and elder care. Additional information is available at healthequity.com.
- Changes are allowed within **30 days of a qualifying event** with deduction beginning the first of the month following receipt by BART Benefits. Requests **past 30 days must wait until Open Enrollment**.
- You must re-enroll during each Open Enrollment to continue your participation in the account you have selected.

Health Care Reimbursement Account	***Dependent Care Reimbursement Account***
$___________	$___________

Flexible Benefits Plan Acknowledgement

I have read and understand the explanation of my options under BART's Flexible Benefits Plan. I understand these elections affect my wages for Federal, State and Medicare taxes. Contributions do not earn interest. I understand the annual pledge will be reduced over the remaining pay periods in a calendar year. Changes are allowed during Open Enrollment, or within 30 days of a qualifying event allowed by the plan. During Open Enrollment, an election must be made to renew participation for the following calendar year or participation will end January 1st. **Unused contributions** for eligible expenses remaining after terminating from the plan will be forfeited. Unused contributions at the end of the plan year will be forfeited unless the participant renews participation for the following plan year. If so, a maximum $570 of unused contributions will carry over to the next plan year. The District may limit one's annual pledge amount in one or both of the accounts above in order to remain in compliance with the IRS.

Medical, Administrative and Enhanced Vision Deduction Acknowledgement

I authorize the District to deduct my portion of medical premiums, administrative fees, enhanced vision premiums (if applicable), and contribution amounts shown above. If no pay is earned while on leave, or a paycheck is insufficient to cover any of the items mentioned above, I am responsible for making payments to the District. If no payments are made, but one returns to work, retroactive premiums, fees, and contributions will be deducted. I understand premiums are subject to change annually and / or through collective bargaining negotiations.

____ **Employee Signature**

____________________ **Date Signed**

For BART Benefits Processing Only

Date Received: ____________________

Benefits Signature: ____________________

Please return to BART Benefits:
Email: benefits@bart.gov
Mail: PO Box 12688 Oakland, CA 94604 Interoffice: HR/Benefits
Fax: (510) *464-7618*

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