

# BAY AREA RAPID TRANSIT DISTRICT

## HEALTH BENEFITS FORM

**Instructions:** **Page 1: Medical Insurance:** Submit within 60 days from the qualifying event date. **Dental, Vision and Domestic Partner Insurance:** Submit within 30 days from the qualifying event date. If you do not 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. **Page 2:** Enroll or Remove dependents. **Page 3:** Make changes to your Flexible Spending Account benefits.

Employee Name: \_\_\_\_\_  
First Middle Last

Employee Number: \_\_\_\_\_

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

#### Plan (Select one)<sup>1</sup>

- |  |   |  |                                       |   |
|--|---|--|---------------------------------------|---|
| <input type="checkbox"/> First Time Enrollee ( <i>Late or Loss of Coverage</i> ) | } | Anthem:                                  | <input type="checkbox"/> EPO          | <input type="checkbox"/> Select HMO       |
| <input type="checkbox"/> Enroll -- Open Enrollment                               |   | <input type="checkbox"/> Traditional HMO | <input type="checkbox"/> PERS Care    |   |
| <input type="checkbox"/> Change Plans – Change Address *                         |   | <input type="checkbox"/> PERS Choice     | <input type="checkbox"/> PER Select   |   |
| <input type="checkbox"/> Change Plans – Open Enrollment                          |   | <input type="checkbox"/> PORAC (Police)  |                                       |   |
| * Must occur within 60 days after changing address.                              |   | Blue Shield:                             | <input type="checkbox"/> Access + HMO | <input type="checkbox"/> EPO              |
| <input type="checkbox"/> Cancel  |   | <input type="checkbox"/> Net Value       | <input type="checkbox"/> Select HMO   |   |
|  |   | <input type="checkbox"/> HealthNet       | <input type="checkbox"/> Kaiser       | <input type="checkbox"/> UnitedHealthcare |

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

#### Plan (Select a vision and / or dental plan)

- |  |   |  |                                |                                   |
|--|---|--|--------------------------------|-----------------------------------|
| <input type="checkbox"/> First Time Enrollee (Part-Time ATU)         | } | Vision Service Plan:                   | <input type="checkbox"/> Basic | <input type="checkbox"/> Enhanced |
| <input type="checkbox"/> Enroll -- Open Enrollment (Part-Time ATU)   |   | Principal Financial:                   | <input type="checkbox"/> Basic |                                   |
| <input type="checkbox"/> Change Plans – Open Enrollment <sup>2</sup> |   |  |                                |                                   |
| <input type="checkbox"/> Cancel Vision                               |   | <input type="checkbox"/> Cancel Dental |                                |                                   |

### Section C: Enroll Dependents – Select all that apply. Go to pages 2 & 3.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adoption / Newborn      | <input type="checkbox"/> Court Order                     | <input type="checkbox"/> Custody Change            |
| <input type="checkbox"/> Dependent Lost Coverage | <input type="checkbox"/> Domestic Partner Adult or Child | <input type="checkbox"/> First Transit Pass        |
| <input type="checkbox"/> Marriage                | <input type="checkbox"/> Open Enrollment                 | <input type="checkbox"/> Parent-Child Relationship |

### Section D: Remove Dependents – Select all that apply. Go to pages 2 & 3

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Custody Change  | <input type="checkbox"/> Death of Dependent             | <input type="checkbox"/> Dependent Moves Out  |
| <input type="checkbox"/> Divorce         | <input type="checkbox"/> Domestic Partnership Ends      | <input type="checkbox"/> Gains Other Coverage |
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Parent-Child Relationship Ends |   |

<sup>1</sup> Eligibility is based on zip code. Go to [www.calpers.ca.gov](http://www.calpers.ca.gov) to find the plans in your zip code.

<sup>2</sup> Change can be made during Open Enrollment that occurs during an even numbered calendar year (e.g., 2014).



**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 Card      **Enroll** – Any dependent
  
- County Death Certificate      **Remove** – Deceased spouse or child
- Entire Divorce Decree      **Remove** – Former spouse or step-children
- Mailing Address      **Remove** – Qualifying event is divorce. 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
<b>Name:</b> (First, Middle, Last)				
<b>Date of Birth:</b>				
<b>Relationship:</b>				
<b>National ID (SSN)</b>				
Medical	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Vision	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Dental	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Transit Pass (Age 5 or older)	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Medical Effective				
Dental Effective				
Vision Effective				

	Dependent #5	Dependent #6	Dependent #7	Dependent #8
<b>Name:</b> (First, Middle, Last)				
<b>Date of Birth:</b>				
<b>Relationship:</b>				
<b>National ID (SSN)</b>				
Medical	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Vision	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Dental	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Transit Pass (Age 5 or older)	<input type="checkbox"/> Enroll <input type="checkbox"/> Remove			
Medical Effective				
Dental Effective				
Vision Effective				



# BAY AREA RAPID TRANSIT DISTRICT

## HEALTH BENEFITS FORM

### Flexible Spending Account Changes

- The **Health Care Reimbursement Account** allows the use of pre-tax dollars to pay for qualifying expenses; which are not 100% covered, or are ineligible for payment, through any group health care plan.
- The **Dependent Care Reimbursement Account** allows the use of pre-tax dollars to pay for qualifying expenses as related to taking care of your children such as day care. Additional information is available at [myspendingaccount.adp.com](http://myspendingaccount.adp.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.

<i>Health Care Reimbursement Account</i>	<i>Dependent Care Reimbursement Account</i>
<input type="checkbox"/> Enroll Annual Pledge Amount: \$ _____	<input type="checkbox"/> Enroll Annual Pledge Amount: \$ _____
<input type="checkbox"/> Change Annual Amount: New Annual Amount: \$ _____	<input type="checkbox"/> Change Annual Amount: New Annual Amount: \$ _____
<input type="checkbox"/> Cancel Participation	<input type="checkbox"/> Cancel Participation
<input type="checkbox"/> No changes	<input type="checkbox"/> No changes

### 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 1<sup>st</sup>. **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 \$500 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

### OFFICE USE ONLY

\_\_\_\_\_  
Benefits Representative Signature

\_\_\_\_\_  
Date Entered

