SEIU & MGMT Employees

Special Enrollment January 2nd - January 15th

COUNTY of VENTURA
County Executive Office
Human Resources/Benefits

Benefits Department 800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email:Benefits.serviceRep@venturacounty.gov

Internet: www.venturacounty.gov/benefits

Instructions: Complete and return this form by the 1/15/26 deadline. All forms and any supporting documentation (if applicable) must be submitted together by close of this special enrollment period for eligible changes to be processed. Submit forms to Benefits.ServiceRep@venturacounty.gov utilizing a delivery receipt. Forms received after the deadline will not be processed.

Are you requesting a medical plan change that qualifies based on the eligible changes outlined below? **Yes** ☐ **No** ☐

Medical Change requested must be consistent with the special election event reason. This means for employees that have a decrease in flexible credit allowance, they may only request a medical change that decreases their bi-weekly medical premiums. For employees that have an increase in flexible credit allowance, they may only request a medical change that increases their bi-weekly medical premiums.

The following two questions must be completed for review and processing of eligible requests:

1. What is your current Medical Plan and Coverage Level (EE Only, EE+1, EE2+)?_____
2. What is your medical enrollment change request (example, change plans)?_____

3. **Employee Data** (please print)

NAME (LAST, FIRST, M.I.)	EMPLOYEE ID NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	GENDER (M/F)	HIRE DATE
AGENCY/DEPARTMENT NAME	BARGAINING UNIT	EMAIL ADDRESS	

☐ 4. **Medical Plan Coverage- Check box to left & new plan enrollment below if applicable** (biweekly premiums BEFORE COV provided Flexible Credit Allowances applied)

- ☐ Ventura County Health Care Plan HMO (EE only = **$463.99**, EE+1 = **$927.02**, EE + 2 or more = **$1,204.84**)
- ☐ Blue Shield Trio HMO (EE only = **$378.01**, EE+1 = **$755.05**, EE + 2 or more = **$981.27**)
- ☐ Blue Shield Access+ HMO (EE only = **$493.79**, EE+1 = **$986.59**, EE + 2 or more = **$1,282.28**)
- ☐ Blue Shield High-Deductible PPO (EE only = **$607.06**, EE+1 = **$1,148.52**, EE + 2 or more = **$1,492.38**)

New Flexible Credit Allowances: (**Full-Time 60+ hours** per biweek) EE Only $463.99, EE +1 $834.32, EE 2+ $1,024.11
(**Part-Time 40-59 hours** per biweek) EE Only $324.79, EE +1 $584.02, EE 2+ $645.19

NOTE: No. 5 & 6 below can only be completed in very limited circumstances.

5. **Health Savings Account** (pre-tax; only available if enrolling/enrolled in the Blue Shield High-Deductible PPO)

☐ I elect a Health Savings Account with a semi-monthly pledge of $ _____
Individual Coverage – Maximum Biweekly Pledge is $183.33 semi-monthly ($225 if age 55 or older)

Family Coverage – Maximum Biweekly Pledge is $364.58 semi-monthly ($406.25 if age 55 or older)

6. **Flexible Spending Accounts** (FSA pre-tax; the below options are only available based on the information provided next to each enrollment option. Any enrollments added by employees that do not meet the specific criterial noted will be disregarded/no enrollment will be processed.

Health Care FSA (this option is only available to employees that are currently enrolled in the HDHP PPO and electing another plan/one of the other 3 HMO plans offered.):
☐ I elect a Health Care Flexible Spending Account with a semi-monthly pledge of $_____($1.00 - $137.50/semi-monthly).

Limited-Purpose FSA (this option is only available if making a medical enrollment change from one of the 3 HMO plans offered to the HDHP PPO plan and enrolling in the Health Savings Account):
☐ I elect a Limited-Purpose Health Care Flexible Spending Account with a semi-monthly pledge of $_____($1.00 - $137.50/semi-monthly).

7. **Employee/Dependent Information** (If newly enrolling in an HMO medical plan, choose a Primary Care Physician. If no PCP is noted, or not available, one will be designated by the insurance company, and you would need to contact the insurance plan directly for any changes needed.)

NAME (LAST, FIRST, M.I.)	RELATION-SHIP	DATE OF BIRTH		GENDER (M/F)	SOCIAL SECURITY NUMBER	MEDICAL	PHYSICIAN NAME (HMO only)	Previously seen Y/N?
Employee	**Self**		**See Page 1**					

8. Signature

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I also understand and agree that:

- I have access to the Benefit Plans Handbook and have reviewed the plans I'm enrolling in. I understand I can visit https://hr.venturacounty.gov/benefits anytime for benefits, eligibility, deadlines, and enrollment information.
- I have reviewed the biweekly health plan premiums "rates" for which I enrolled and/or continued enrollment.
- My coverage elections on this form cannot be revoked or modified until the next open enrollment period, unless I have a qualifying change in status as defined by the IRS (see Benefit Plans Handbook, Chapter 1).
- I must submit any enrollment changes before the deadline
- I will verify that the enrollments and deductions I have authorized on this form have been implemented by reviewing my paystub for accuracy during the first pay period my selections are effective. I agree that failure to report an error within 30 days of the error's first appearance on my biweekly paystub is an affirmative election of the benefits listed on the paystub.
- I am responsible for submitting mid-year changes within 60 days of a qualifying life event, including the event date (e.g., birth, adoption, marriage, divorce, or gain/loss of coverage). See the Benefit Plans Handbook, Chapter 1 at https://hr.venturacounty.gov/benefits.
- I will notify the County immediately if I and/or my dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible.
- I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments.
- My pre-tax pay will be reduced by the amount of any required contributions noted for the coverage(s) elected after my flexible credits have been applied (premiums and flexible credit amounts are listed on page 4 of this form). My unspent flexible credits will be taxed and added to my paycheck as "Cash Back."
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I am enrolling.
- I understand I should not remove a spouse or their dependents from coverage in anticipation of or during a divorce. If removal is necessary, I will first obtain court permission. I must notify COV Benefits of any changes related to a spouse or dependents during a divorce, including during open enrollment.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s).
- A photocopy of this form is as valid as the original.
- If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.

Signature_____ **Date**_____

FOR OFFICE USE ONLY		
Department (Sign & Date)	HR/Benefits (Sign & Date)	Effective Date

Employees could potentially add dependents if they had an increase in Flexible Credit Allowance AND the plan change requested increases their current bi-weekly medical plan premiums. We will disregard any dependent enrollment that does not meet this criteria.

*******Important****If you meet the above criteria and are adding a dependent who is not currently enrolled in one of your other plans (MetLife Dental and/or EyeMed Vision) you must attach proof of dependent eligibility:**

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
SPOUSE Your current legal husband or wife	• Copy of page 1 of your most-recently filed federal tax return (as filed) listing spouse (financial data may be blacked out), **OR** • Copy of official marriage certificate
REGISTERED DOMESTIC PARTNER Your domestic partner who is registered with you through the State of California or any other California County or Municipality's domestic partner registry	• Copy of Declaration of Domestic Partnership (as filed with the official domestic partner registry), **AND** • Proof relationship is still current (a copy of a utility bill with your registered domestic partner's name on it that is mailed to your home on a regular basis and dated within the past 60 days.)
CHILD* under the age of 26 Your child under the age of 26 (Certain unmarried children, if handicapped prior to age 26 and continuously covered by a County-sponsored medical plan since prior to age 26, and incapable of self- support may be eligible beyond age 26, if proper documentation of disability is submitted)	One of the following: • Copy of page 1 of your most-recently filed federal tax return (as filed) listing child as dependent, **OR** • Copy of birth/adoption certificate, Qualified Medical Child Support Order. **AND** • Current residence and mailing address, if different than employee

* **The basic definition of "child" is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse or registered domestic partner, or both.**

*In the event of a discrepancy between what is stated on this form and what is stated in the County of Ventura's Benefit Plans Handbook or approved Board of Supervisors Health Plan Rates, the information indicated in the Benefit Plans Handbook and approved Board letter shall be the deciding authority.

Most birth certificates and marriage certificates can be ordered online at www.vitalchek.com, if you don't already have a copy. For copies of court documents such as adoption or guardianship proceedings, you can contact the Clerk of Court's office where the proceedings took place. Any costs you may incur to obtain your documents will be at your expense.

If you are unable to obtain any of the required documents, please contact County Benefits immediately to determine if there are acceptable alternatives.

Notice to Current and Upcoming Leave of Absence Employees

Leave of absence employees have the same rights and responsibilities/deadlines related to any mid-year/life event change, open enrollment or special enrollment periods available to them.

Employees on a leave of absence are still responsible for submitting any eligible mid-year change requests by the applicable deadline—even if they are not currently making health plan payments due to their leave status.

Unless a qualifying mid-year change was submitted within the deadline or changes were made during Open Enrollment or if applicable a special enrollment period, employees returning from leave will have their **prior health plan elections reinstated**.