San Juan Unified School District
Open Enrollment Change Check List

Please note that no vision changes are permitted due to the special vision enrollment held in August.

1. Complete all five sections of the Employee Benefits Enrollment Change form:

Section I – Employee Information

- Enter your Last Name, First Name, Middle Initial
- Enter your Social Security Number
- Enter your physical address and mailing address
- Enter the email address you wish for us to contact you if we have any questions
- Enter your primary phone number

Section II – Reason for Change

- Check the Open Enrollment Box and note the effective coverage date as 01/01/2020
- If switching plans, check the switch medical or dental plan (whichever is applicable and note which plan you are leaving and which plan you are switching to.
- If you are cancelling your medical coverage, check the switch medical plan from (Name the medical plan you are cancelling) to Waiving. You need to complete a medical wavier form in addition to completing this form and you will need to provide proof of other medical coverage which is not coverage through Covered California or purchased on the individual market. A copy of your insurance card is sufficient proof of coverage.
- If adding dependents you need to check the add dependents box.
- If deleting dependent, you need to check the remove dependent box.

Section III– Benefit Plan Coverage Election

- If you are switching from one medical or dental plan to another, you need to check the medical or dental enroll box and select the box for the medical or dental plan you wish to enroll and the box for the level of coverage you desire for the new plan: Employee only, employee + 1, or Employee plus family (2 or more dependents)
- If you are cancelling your medical coverage, you need to check the Decline Coverage box and check the plan name medical provider that you are cancelling.
- If adding dependents to your existing medical and /or dental plan, check the change box and then check the box of the medical and/or dental plan you are adding your dependent(s) to and check the coverage level you desire.
- If deleting dependents to your existing medical and/or dental plan, check the change box and then select the medical and/or dental plan that you are deleting your dependent from and check the new desired level of coverage.

Section IV – Employee/ Dependent Information

- If you are switching medical or dental plans, you need to check the ADD box for the health plans you wish to enroll in. You need to list the name(s) of the individuals that are to be covered on the new plan, their social security number, birth date, and sex. If coverage is with Western Health Advantage, you need to designate the medical group you wish to be assigned. If you do not select the medical group, Western Health will assign you to a medical group.

- If you are cancelling your medical coverage, check the drop action box under medical and note the names, social security number and birthdates for everyone that is being dropped by cancelling the coverage.
- If you are adding a dependent to your current plan(s), you need to check ADD box on the line(s) where you will provide the name of the individuals you are adding to your coverage, social security number, sex, birth date, coverage, and medical group if your coverage is with Western Health Advantage.

- If you are deleting a dependent from your current plans, you will need to check DROP box next to the line(s) where you will provide the name, social security number, sex, birth date, and coverage for the individual you are deleting from your coverage.

Section IV

- **Si**gn and Date the form
- Sign the Arbitration Agreement for the Medical Carriers on Page 2 of the Enrollment Change Form.

2. Make a copy of the completed form for your records.

3. Attach the required proof of dependency if you are adding a dependent who has never been previously covered under your coverages with the San Juan School District.

Spouse – Copy of Marriage Certificate
Domestic Partner – Copy of Court Approved Domestic Partnership
Child – Copy of Birth Certificate

Attach a medical waiver form and proof of other medical coverage if you are cancelling your medical coverage.

4. Submit your change form and required proof of dependency to the Benefits Office by **November 22, 2019.**