ANNUAL HEALTH PLAN OPEN ENROLLMENT ELECTION FORM
FOR BENEFITS ELIGIBLE ADJUNCT FACULTY
9/14/2026 - 9/22/2026

PLEASE COMPLETE & RETURN ALONG WITH ENROLLMENT FORMS BY SEPTEMBER 22, 2026.

EMPLOYEE NAME: _____ **DEPARTMENT:** _____

Effective 9/1/2026, I wish to enroll in the following plan(s):

Select one	***Select all that apply***
DISTRICT-PAID BENEFIT	**PURCHASED BENEFIT(S)**
☐ Kaiser	☐ Kaiser
☐ Single Party	☐ Two-Party
	☐ Family
☐ Delta Care HMO	☐ Delta Care HMO
☐ Delta Dental PPO	☐ Delta Dental PPO
☐ Vision Service Plan	☐ Vision Service Plan

After indicating your enrollment choices above, **please sign this form** and **complete the plan enrollment form(s)** for each plan you are electing.

If you are enrolling in District health benefits for the **first time, or** are **re-enrolling** in benefits for the Fall 2026 Semester, please **disregard** the subsequent sections pertaining to **plan/dependent changes**.

PLAN CHANGES: *(**CHECK ALL CHANGES THAT APPLY**)*

☐ **CHANGE TO EXISTING ENROLLMENT**. (Please checkmark ALL THAT APPLY below.)
- ☐ CHANGE MY DISTRICT-PAID COVERAGE (i.e. from Kaiser HMO to Delta Dental PPO)
- ☐ PURCHASE ADDITIONAL COVERAGE
- ☐ CHANGE MY PURCHASED COVERAGE
- ☐ CANCEL MY PURCHASED COVERAGE

☐ **CANCEL ALL COVERAGE**

DEPENDENT CHANGES: (CHECK ALL CHANGES THAT APPLY)

☐ **Change to current HEALTH Coverage.** I would like to make changes to the dependents on my medical plan. I have attached proof of dependency (if adding dependent/s).

☐ ***Add Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

☐ ***Delete Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

☐ **Change to current DENTAL Coverage.** I would like to make changes to the dependents on my dental plan. I have attached proof of dependency (if adding dependent/s).

☐ ***Add Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

☐ ***Delete Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

☐ **Change to current VISION Coverage.** I would like to make changes to the dependents on my vision plan. I have attached proof of dependency (if adding dependent/s).

☐ ***Add Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

☐ ***Delete Dependent(s)***

NAME: _____ DOB: _____ SSN: _____

All dependents are subject to verification of eligibility. Please provide supporting documentation such as birth certificates and/or marriage certificates along with your enrollment forms for all dependent additions. In order to enroll in coverage for the first time, re-enroll in coverage, or add a coverage type, the ***plan enrollment form(s)*** *must also be submitted along with this* ***Open Enrollment Election Form****.*

Signed: _____ Date_____

A SPECIAL NOTE ABOUT MID-YEAR PLAN CHANGES

In order to change your election after the Plan Year has begun, you must experience a qualified Change in Status Event.

Election changes due to a Change in Status Event must be made within a reasonable time (usually 30 days before or after the event unless otherwise specified in Summary Plan Description) AND must be consistent with the change that took place as defined by the IRS Consistency Rule. The effective date of the election brought forth by the Change in Status Event is the later of the: (1) date of the Change in Status Event, or (2) the date you requested the change, except for the birth or adoption of a child where HIPAA special enrollment rules apply.

The following chart outlines the qualifying Change in Status Events:

Types of Qualified Status changes:

- ☐ **Change in legal marital status**- Marriage, divorce, death of spouse, legal separation, and annulment.
- ☐ **Change in the number of tax dependents** – Birth, adoption, placement for adoption, and death of a dependent
- ☐ **Change in employment status of the employee, employee's spouse or employee's dependent(s)** – Termination or commencement of employment, strike or lockout, commencement of, or return from an unpaid leave of absence, a switch between part-time and full-time employment, or a change in worksite.
- ☐ **Dependent satisfies (or ceases to satisfy) dependent eligibility requirements** – Due to attainment of limiting age under the insurance plan, etc.
- ☐ **Residence change of the employee, employee's spouse, or employee's dependent(s)** – Only allowable if the change in residence affects the employee's eligibility for coverage.
- ☐ **Gain/Loss of other coverage**- change in coverage of spouse or dependent under another employer's plan,*
- ☐ **Qualified Medical Child Support Order**

Consistency Rule

In order to change your election, the change must be on account of and correspond with a **Change in Status Event** that affects you, your spouse or your dependent's eligibility for the employer-sponsored benefit plan(s). In other words, the increase or decrease in your flexible benefit plan election amount must be consistent with the gain or loss of your eligibility to participate. If the Change In Status Event does not affect the eligibility of that insurance and/or out-of-pocket medical expense you cannot make the change. Special consistency rules also apply for the following situations: loss of dependent eligibility, gain of coverage eligibility under another employer's plan, and life or disability coverage.

YOU MUST NOTIFY A BENEFITS REPRESENTATIVE WITHIN 30 DAYS OF YOUR STATUS CHANGE