Open Enrollment
Enrollment Change Form

☐ No Changes

1 ENTER YOUR PERSONAL INFORMATION

Name *(Last, First, M)*: _____

Address: _____

City _____ State: _____ Zip: _____

To Be Completed By Employer
Reason For Change: Open Enrollment
Effective Date: 7/1/2022
Annual Salary: _____
Class: _____ Rec'd Date _____
HealthNet # BYS29A Kaiser 602272
Guardian Dental, Vision, # 458105

2 Select Your Medical Plan—Kaiser or HealthNet (HN)

☐ WAIVE MEDICAL

☐ Kaiser Plat HMO ☐ Kaiser HSA 2500 ☐ HN WholeCare HMO 20 ☐ HN GF HMO 35 ☐ HN Silver PPO ☐ HN Bronze HSA

Who Will Be Covered by Your Medical Plan?

☐ Myself Only ☐ Myself + My Spouse ☐ Myself + My Child(ren) ☐ Myself + My Family

3 Enroll in Your Dental Plan

☐ WAIVE DENTAL

☐ Guardian Dental PPO

Who Will Be Covered by Your Dental Plan?

☐ Myself Only ☐ Myself + My Spouse ☐ Myself + My Child(ren) ☐ Myself + My Family

4 Enroll in Your Vision Plan

☐ WAIVE VISION

☐ Guardian Vision VSP

Who Will Be Covered by Your Vision Plan?

☐ Myself Only ☐ Myself + My Spouse ☐ Myself + My Child(ren) ☐ Myself + My Family

5 Complete This Section for Flexible Spending Account (FSA) and/or HSA

Medical FSA (IRS Maximum $2,850) Annual Election $ _____

Dependent Care FSA (IRS Maximum $5,000) Annual Election $ _____

Commuter/Transit (IRS Maximum $280 per month) Annual Election $ _____

Health Savings Account (HSA 2022 / 2023)

Single $3,650, Family $7,300) Annual Election $ _____

Catch-up $1,000 (Age 55+) Annual Election $ _____

See Page 2

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6

☐ This section is blank

7

This section is blank

8 Complete This Section for All Dependents *(update beneficiary for life insurance)*

Relationship *(Check one)*: ☐ Spouse ☐ Beneficiary for Life Insurance ___________ indicate percentage

Name *(Last, First, M)*:

____ *Birthdate* ___________ Gen *(M/F)*:_____ Social Security Number:________-______-_________

Relationship *(Check one)*: ☐ Child ☐ Disabled Dependent ☐ Beneficiary for Life Insurance ___________ indicate percentage

Name *(Last, First, M)*:

____ *Birthdate* ___________ Gen *(M/F)*:_____ Social Security Number:________-______-_________

Relationship *(Check one)*: ☐ Child ☐ Disabled Dependent ☐ Beneficiary for Life Insurance ___________ indicate percentage

Name *(Last, First, M)*:

____ *Birthdate* ___________ Gen *(M/F)*:_____ Social Security Number:________-______-_________

Relationship *(Check one)*: ☐ Child ☐ Disabled Dependent ☐ Beneficiary for Life Insurance ___________ indicate percentage

Name *(Last, First, M)*:

____ *Birthdate* ___________ Gen *(M/F)*:_____ Social Security Number:________-______-_________

9 Additional forms needed for the Retirement, Legal Shield, and UNUM plans

Sign in box:

Date: ________________________________