

# Open Enrollment Enrollment Change Form

☐ No Changes



<b>1</b>	<b>ENTER YOUR PERSONAL INFORMATION</b>	<i>To Be Completed By Employer</i> Reason For Change: Open Enrollment Effective Date: 7/1/2024 Annual Salary: _____ Class: _____ Rec'd Date: _____ HealthNet # BYS29A Kaiser 602272 Guardian Dental, Vision, # 458105
	Name (Last, First, M): _____ Address: _____ City: _____ State: _____ Zip: _____	
<b>2</b>	<b>Select Your Medical Plan—Kaiser or HealthNet (HN)</b>	<input type="checkbox"/> <b>WAIVE MEDICAL</b>
	<input type="checkbox"/> Kaiser Plat HMO <input type="checkbox"/> Kaiser HSA <input type="checkbox"/> HN WholeCare HMO <input type="checkbox"/> HN GF HMO 35 <input type="checkbox"/> HN Silver PPO <input type="checkbox"/> HN Bronze HSA	
	<b>Who Will Be Covered by Your Medical Plan?</b>	
	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself + My Spouse <input type="checkbox"/> Myself + My Child(ren) <input type="checkbox"/> Myself + My Family	
<b>3</b>	<b>Enroll in Your Dental Plan</b>	<input type="checkbox"/> <b>WAIVE DENTAL</b>
	<input type="checkbox"/> Guardian Dental PPO	
	<b>Who Will Be Covered by Your Dental Plan?</b>	
	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself + My Spouse <input type="checkbox"/> Myself + My Child(ren) <input type="checkbox"/> Myself + My Family	
<b>4</b>	<b>Enroll in Your Vision Plan</b>	<input type="checkbox"/> <b>WAIVE VISION</b>
	<input type="checkbox"/> Guardian Vision VSP	
	<b>Who Will Be Covered by Your Vision Plan?</b>	
	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself + My Spouse <input type="checkbox"/> Myself + My Child(ren) <input type="checkbox"/> Myself + My Family	
<b>5</b>	<b>Complete This Section for Flexible Spending Account (FSA) and/or HSA</b>	
	Medical FSA (IRS Maximum \$3,200)	Annual Election \$ _____
	Dependent Care FSA (IRS Maximum \$5,000)	Annual Election \$ _____
	Commuter/Transit (IRS Maximum \$315 per month)	Annual Election \$ _____
	<b>Health Savings Account (HSA 2024 Limits)</b>	
	Single \$4,150   Family \$8,300	Annual Election \$ _____
	Catch-up \$1,000 (Age 55+)	Annual Election \$ _____

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**6**

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**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: \_\_\_\_\_