MID-YEAR SPECIAL OPEN ENROLLMENT HEALTH INSURANCE CHANGE FORM

Return completed form to Human Resources Benefits Division before 12/05/2023 in person at
400 E. Main Street, 3rd Floor, Stockton CA 95202 or via email Benefits@stocktonca.gov
New plans and rates are effective 1/1/2024, new payroll deductions are effective 1/22/2024

EMPLOYEE INFORMATION

Last Name	**First Name**
Munis ID	**Group/BU**
Address	**Phone number**
City	**State/ZIP**

DEPENDENT INFORMATION

◯**ADD** ◯**DELETE**

Last Name	**First Name**
DOB	**Relationship**
Last Name	**First Name**
DOB	**Relationship**

MEDICAL PLANS INFORMATION

Health plans listed below are offered to employees of all represented and unrepresented groups, however, employee contributions are determined through the collective bargaining process. These plans include medical, dental and vision. Please refer to 2023-2024 Health Plan Rates to view applicable employee deductions.

	Kaiser POS/Dental DHMO	**Kaiser POS/Dental DPPO**	**Kaiser HDHP/Dental DHMO**	**Kaiser HDHP/Dental DPPO**	**Kaiser HMO/Dental DHMO**	**Kaiser HMO/Dental DPPO**	**Sutter HDHP/Dental DHMO**	**Sutter HDHP/Dental DPPO**	**Sutter HMO/Dental DHMO**	**Sutter HMO/Dental DPPO**
EE Only	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
EE + 1	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
EE + Fam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

HSA/FSA SELECTIONS

I would like to participate in the following:

◯ HSA plan (only available if High Deductible Health Plan is elected) and contribute $_____ per pay period

◯ FSA plan and contribute $_____ per pay period

MEDICAL OPT OUT ACKNOWLEDGEMENT

◯ **I DECLINE MEDICAL AND PRESCRIPTION COVERAGE**

*By checking this box and signing this form, you are acknowledging that you were offered medical and prescription coverage through the City of Stockton for you and your eligible dependents, and you have declined to enroll in this coverage. You may still enroll in dental and/or vision coverage below. If you are married to, or a dependent of, a City of Stockton employee, you cannot have double coverage on medical, dental, and vision plans offered by the City of Stockton.

DELTA DENTAL	**DPPO**	**DHMO**	**VISION**	**VSP**
EE Only	◯ **$0.00**	◯ **$0.00**	EE Only	◯ **$0.00**
EE + 1	◯ **$0.00**	◯ **$0.00**	EE + 1	◯ **$0.00**
EE + Fam	◯ **$0.00**	◯ **$0.00**	EE + Fam	◯ **$0.00**

By signing below, I certify that the information provided herein is true and accurate to the best of my knowledge, and I understand all of the acknowledgements and disclaimers listed in this document.

Employee Signature Date