FRESNO UNIFIED SCHOOL DISTRICT

2309 Tulare Street Fresno, CA 93721 (559) 457-3520 Fax No. (559) 457-3760

Open Enrollment Form

EFFECTIVE: JANUARY 1, 2021

Part-Time Employees

1. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID	☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNERSHIP ☐ DIVORCED ☐ WIDOWED
MAILING ADDRESS		BIRTHDATE / TELEPHONE NO.	☐ MALE ☐ FEMALE
CITY STATE ZIP CODE		DEPT./SITE	

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE? ☐ FUSD ☐ OTHER: _____

Are you or any family members covered by another group plan? ☐ YES ☐ NO _____
GROUP PLAN NAME

Are you the parent/guardian of a FUSD employee that is under the age of 26? ☐ YES ☐ NO If yes, what is your dependent child's name and employee ID#? _____

Are you the dependent child of a FUSD employee? ☐ YES ☐ NO If yes, are you covered under that employee's health plan? ☐ YES ☐ NO

Please provide the name and employee ID # of the person whom you have FUSD coverage through: _____

2. FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF: SSN COPY / BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES **AND** if married or in a Domestic Partnership, front page of your most recently filed federal tax return (1040 form)

FIRST NAME	LAST NAME	GENDER	AGE	BIRTHDATE	SOCIAL SECURITY
☐ DOMESTIC PARTNER ☐ SPOUSE		M / F			
☐ SON ☐ DAUGHTER		M / F			
☐ SON ☐ DAUGHTER		M / F			
☐ SON ☐ DAUGHTER		M / F			
☐ SON ☐ DAUGHTER		M / F			
☐ SON ☐ DAUGHTER		M / F			

3. CHANGE ENROLLMENT AS INDICATED:

UHC Dental Direct

Plan coverage includes:
Office Exam, X-Rays, and
Two (2) Cleanings Annually

Includes Orthodontic coverage for dependents and adults.
Some procedures may require co-payments.

Rates include family coverage at no additional cost.

10 Month Employee $ 52.49
12 Month Employee $ 43.75

****MUST USE UHC DENTAL DIRECT PROVIDERS****

☐ Employee Only ☐ Delete Employee
☐ Add Dependent ☐ Delete Dependent
☐ Add Family ☐ Delete Family

Medical Eye Services (MES)

Plan coverage includes:
Exam - Once Every 12 months - $ 5 Co-pay
Lenses - Once Every 12 months (If prescription changes)
Frames - Once Every 24 months (Frames or Contact Lenses, up to $130)

Rates include family coverage at no additional cost.

10 Month Employee - $ 14.58 / CSEA Member 3 + yrs $ 9.11
12 Month Employee - $ 12.15 / CSEA Member 3 + yrs $ 7.59

☐ Employee Only ☐ Delete Employee
☐ Add Dependent ☐ Delete Dependent
☐ Add Family ☐ Delete Family

- **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.**
- **Please notify the Benefits Office of any change in Health Coverage within 31 days of event**
- **You are required to notify the District within 60 days following the date on which any dependent no longer meets the eligibility criteria for dependent coverage (including divorce or legal separation; and the termination, dissolution or nullification of Domestic Partnership). Failure to notify the District within the required time period may cause you to be responsible for the reimbursement of any claims paid for ineligible dependents.**

Verified by:	Effective Date:

EMPLOYEE SIGNATURE_____ **Date** _____