Ancillary Coverages
Entity Enrollment Form

ENTITY INFORMATION – The Entity applicant certifies the following information:

Entity's Legal Name: Certna	Bakersfield	CA	93301
Physical Street Address: 1115 Truxtun Avenue	Physical City: Bakersfield	State: CA	Zip: 93301
Mailing Address: 1115 Truxtun Avenue	Mailing City: Bakersfield	State: CA	Zip: 93301
County: Kern	Email:		
Contact Name: Richard Sherman	Title: Operations Director	Phone Number: (714) 400-8188	Fax Number:

Type of Organization: ☐ Public Entity ☒ JPA ☐ Other – please specify ____________________

Organization Federal Tax ID Number: 26-2536914

COVERAGE(S) REQUESTED AND CONTRIBUTIONS The Entity selects the following coverages to be available for the enrollees and will contribute the following percentage of the charge/premium on behalf of its enrollees for the coverage(s) requested below:

☒ **Delta Dental**

Entity contributes the following % toward premium cost:

Full-Time Employee 100% Dependent ___% Public Official ___%

Part-Time Employee ___% Retirees ___%

Select One Plan Below for All Delta Dental PPO Enrollees:

- ☐ **Low Plan**
- ☐ **Medium Plan**
- ☒ **High Plan**

☐ **Delta Dental DeltaCare HMO Plan**

Entity contributes the following % toward premium cost:

Full-Time Employee ___% Dependent ___% Public Official ___%

Part-Time Employee ___% Retirees ___%

Select One Plan Below for All Delta Dental HMO Enrollees:

- ☐ **10A**
- ☐ **11A**
- ☐ **12A**

☒ **Vision Service Plan**

Entity contributes the following % toward premium cost:

Full-Time Employee 100% Dependent ___% Public Official ___%

Part-Time Employee ___% Retirees ___%

Select One Plan Below for All Enrollees:

- ☒ **Option 1 Plan A**
- ☐ **Option 2 Plan B**
- ☐ **Option 3 Plan B**
- ☐ **Option 4 Plan C**
- ☐ **Option 5 Plan C**

☐ **VOYA Basic Life and AD&D**

Select One Plan Below:

☐ 10+ Lives

☐ Less than 10 Lives

Please list life insurance amount on Participant Enrollment Form

The life insurance amount must be the same for all employees in that class or bargaining unit

☐ We intend to make **Supplemental Life** available to Employees

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☐ **VOYA STD Short Term Disability**

Select One Plan Below:

☐ 10+ Lives

☐ Less than 10 Lives

Please list annual salary on Participant Enrollment Form

Select One Option Below:

☐ **Option 1 - 52 Weeks**

☐ **Option 2 - 26 Weeks**

☐ **Option 3 - 13 Weeks**

☐ **VOYA LTD Long Term Disability**

Select One Plan Below:

☐ 10+ Lives

☐ Less than 10 Lives

Please list annual salary on Participant Enrollment Form

Select One Option Below:

☐ **Option 1 - 90 days**

☐ **Option 2 - 180 days**

☒ **MHN Employee Assistance Program**

Cash-In-Lieu of Ancillary Benefits

Check here ☐ If you intend to provide to employees monthly Cash-In-Lieu if they do not enroll in ancillary benefits through SDRMA's Ancillary Benefits program.

Total monthly dollar amount (cash-in-lieu) provided to employee(s): ________

PUBLIC OFFICIALS

For Public Officials to be covered under SDRMA Ancillary Coverages the Public Officials must currently be covered through the Entity's existing ancillary coverages.

Check here ☐ If you intend to continue providing ancillary coverages to your Public Officials through SDRMA Ancillary Coverages.

Total number of public officials: ____________
Total number of enrolling public officials: ____________

EMPLOYEE ELIGIBILITY

Eligible employees are:

- ☒ Active full-time benefit eligible employees who work at least 30 hours per week
- ☐ Part-time benefit eligible employees working at least 20 hours per week
- ☐ Early Retirees (under age 65); if coverage is waived at any time retirees are not eligible to re-enroll in coverage.
- ☐ Medicare Retirees (age 65 or over); if coverage is waived at any time retirees are not eligible to re-enroll in coverage.

Total number of employees: 2 Total number of employees eligible: 2
Total number of active full-time eligible enrolling employees: 2 Total number of part-time eligible enrolling employees: 0

PROBATIONARY PERIOD/ELIGIBILITY DATE

Eligibility Date is always on the **FIRST DAY of the month following Date of Hire**

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DOMESTIC PARTNERS

A Domestic partner is the *employee's or retiree's* domestic partner under a legally registered and valid domestic partnership or active and valid affidavit of domestic partnership.

For an employee or retiree to include their domestic partner as a *dependent under the plan*, the *employee* or *retiree* and their *domestic partner* must meet the following criteria:

a. Both persons must share a common residence
b. Neither person can be married to someone else nor be a member of another domestic partnership with someone else that has not been terminated, dissolved, or nullified
c. The two individuals are not related by blood in a way that would prevent them from being married to each other in the state of California
d. Both persons must be at least 18 years of age
e. Both persons must be capable of consenting to the domestic partnership
f. Both partners must provide the *plan administrator* with a California State Registration of Domestic Partnership or a signed, notarized, Affidavit of Domestic Partnership certifying they meet all of the requirements set forth above in a. through e.

Check here ☐ If per agency internal guidelines you allow **signed, notarized, Affidavit of Domestic Partnership**

**Please note that a Domestic Partnership that is entered into per an affidavit is not a mid-year qualifying event that allows a Domestic Partner and their children to be added to coverage outside of the new hire enrollment period or Open Enrollment.*

SURVIVING SPOUSE/DEPENDENT COVERAGE

Check here ☐ If you intend to provide dental and/or vision coverage to surviving spouse/dependent(s) of employee's or retiree's through your policy with SDRMA. The dental and/or vision coverage is outside of COBRA coverage offering.

CURRENT CARRIER(S)

Is this plan intended to replace any existing group coverage? ☒ YES ☐ NO

If YES, name of group carrier(s): San Bernardino County

Current group carrier proposed termination date: December 31, 2021

GENERAL AGREEMENT AND SIGNATURE

Effective date requested: November 1, 2021 (Actual date will be assigned by SDRMA if application is accepted)

Application is hereby made to SDRMA or the appropriate affiliated company for a Group Benefit Agreement/Group Policy providing coverage identified above. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Entity and SDRMA. This application will become part of that Agreement/Policy.

Upon acceptance of the application, the Entity will inform all persons who are eligible for coverage that they may apply for SDRMA coverage under the Agreement/ Policy.

I understand and agree to all of the above and by signing confirm that all information provided is true and correct.

Date: ____________________

By: ____________________ (Authorized Signature)

Name and Title: Richard Sherman, Operations Director (Print Name and Title of Authorized Signer)

UNDERWRITING USE ONLY

Application is: ☐ Accepted ☐ Declined Case No.____________

Effective: ____________ Underwriter: ____________ Date: ____________

Date: ____________ By: ____________ (Signature)

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