- **All forms attached are your County provided, and optional benefit enrollment forms.**
- **These forms are provided in advance, however, to better explain your options and how to complete, do not fill out until after attending the New Employee Benefits Orientation.**
- **Your Dept. Payroll clerk will notify you of the date and time to attend. You will receive an invite through Microsoft Outlook for a virtual Teams Meeting on your scheduled date and time.**
- **More instructions will be provided to you in this invite including additional forms that you may want to print in advance before attending.**
- **These forms can be filled out electronically with a digital signature or printed and signed with your original signature. Then all forms can be scanned and emailed directly to your assigned HR Benefits Assistant (shown below), after you attend the Orientation.**
- **The 1st page of the packet is a Benefits Checklist for you to use and then turn in along with your completed forms.**
- **PLEASE ACCEPT THE MEETING INVITE ONCE YOU RECEIVE IT.**

Last Name	HR Assistant	Contact Information
A - CRZ	Amanda Meadows	707-784-6173 ameadows@solanocounty.gov
CSA – HAR	Kandas Altman	707-784-3425 kjaltman@solanocounty.gov
HAS – MER	Chelsea del Toro	707-784-3268 crdeltoro@solanocounty.gov
MES - SAN	Shartara Haynes	707-784-6177 smhaynes@solanocounty.gov
SAO - Z	Jazmin Farias	707-784-6115 jfarias@solanocounty.gov

SOLANO COUNTY EMPLOYEE BENEFITS CHECKLIST

DATE _____

NAME _____ SSN _____
Last First M

DEPARTMENT _____ WORK% _____ HIRE DATE _____

IF KEEPING ANY FORMS:

I understand that it is my responsibility to return the following forms within 30 days from my date of hire. **(Place a check before the forms that you are not submitting with checklist)**

Medical _____ Waiver/Auth _____ Dental _____Vision _____ Life _____

Employee Signature_____

PLEASE COMPLETE

- ☐ OATH OF OFFICE
- ☐ CONFIRMATION OF RECEIPT
- ☐ PREMIUM PAYMENT PLAN
- ☐ BASIC LIFE INSURANCE
- ☐ LONG TERM DISABILITY (UNITS 16, 17, 18, 19S, 19E, 60, 61, 62, 62C ONLY)
- ☐ SUPPLEMENTAL LIFE Eff Date: _____ (OPTIONAL)
- ☐ VISION SERVICE PLAN ***Standard or Buy-Up***
- ☐ DENTAL ***Delta Dental or UnitedHealthcare Dental*** (ONLY CHOOSE ONE)
- ☐ FLEXIBLE SPENDING ACCOUNT (OPTIONAL)
- ☐ EMPLOYEE BENEFIT WAIVER FORM
- ☐ PERS MEDICAL BENEFIT ELIGIBILITY FORM (ONLY IF WAIVING MEDICAL)
- ☐ CALPERS MEDICAL HBD-12 ENROLL FORM Provider: _____
- ☐ SOCIAL SECURITY FORM SSA-1945(BARGAINING UNITS 03,12,13 ONLY)
- ☐ CALPERS BENEFICIARY DESIGNATION(Optional go to www.mycalpers.ca.gov to register beneficiaries)
- ☐ 401(a) ENROLLMENT FORM (BARGAINING UNITS 11, 60, 61, 62, 62C ONLY)
- ☐ PROOF OF ELIGIBILITY FOR DEPENDENTS (marriage certificate for spouse, birth certificate for children)

COMMENTS:

_____

County of Solano County

Premium Payment Plan
Election Form

The Premium Payment Plan allows you to use pre-tax (or tax free) dollars to pay for your group health insurance premiums.

☐ I understand that my insurance premiums will be reduced from my salary on a pre-tax basis.

PRINT NAME: _____

SIGNATURE	DATE

Please return to Human Resources

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND DISABILITY INCOME INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Public Risk Innovation, Solutions and Management (PRISM) Effective Date of Coverage or Change _____
Group/Plan Number 316407 Account Number/Location **0048 - County of Solano**
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to *(Check all that apply.)*:
☒ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____
[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____

DISABILITY INCOME INSURANCE

Monthly Income Benefits (LTD)

☐ Elect Coverage - Legislative, Executive, Senior and Mid Management Employees.
(Note: LTD coverage is employer provided. It is contributory for employees working less than 40 hours per week).

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☒ Employee Only—Elect Coverage. (Note: Basic Life and Basic AD&D insurance is employer provided.)

Supplemental Life Insurance

Guaranteed Issue (GI) Limit = $200,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to $500,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. *($10,000 increments, not to exceed 3 TIMES MY ANNUAL SALARY)*
☐ Total supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

BENEFICIARY INFORMATION *(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)*

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

.

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to $20,000 in coverage without evidence of insurability. Total Spouse coverage up to $250,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Spouse coverage is limited to 50% of the employee's supplemental coverage amount.

Spouse Name *(First, Middle Initial, Last)* _____ Birth Date _____

Spouse Life Insurance Election

☐ I currently have Spouse Life coverage of: $_____.
☐ I am applying for additional Spouse Life coverage of: $_____. *($5,000 increments)*
☐ Total Spouse Life coverage (current plus additional): $_____.
☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

Children Life Insurance Election

☐ $ 2,000 for each eligible child
☐ $ 4,000 for each eligible child
☐ $ 6,000 for each eligible child
☐ $ 8,000 for each eligible child
☐ $10,000 for each eligible child
☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			**Phone ( )**

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			**Phone ( )**
2			☐M ☐F	
	Address			**Phone ( )**
3			☐M ☐F	
	Address			**Phone ( )**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee Signature _____ Date _____

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

VISION SERVICE PLAN ELIGIBILITY FORM

Employee Name:
(Please print) **Last** **First** **MI**

SSN: **Date of Birth:**

Vision Plan (Select One):

Standard Plan: No Employee Contribution for Full Time ☐

Buy Up Plan: $9.82/month Employee Contribution for Full Time ☐

VSP Effective Date:

Eligible Dependents: Spouse and dependent children up to the age of 26

Spouse Name Last (if different)	First	MI	**DOB** (Month Day Year)	**Sex** M F	**Add/ Delete**	**SSN**
Marriage Date:						
Child Name Last (if different)	First	MI	**DOB** (Month Day Year)	**Sex** M F	**Add/ Delete**	**SSN**

Employee Signature: _____ **Date:** _____

Enrollment Form

Group Dental Coverage

Provided by Dental Benefit Providers of California, Inc.

UnitedHealthcare Dental®

Check the Appropriate Boxes

Requested Effective Date of Coverage / Date of Change: / / ☒ Enroll ☐ Cancel ☐ Change

Reason:
☐ New Group Plan ☒ New Hire ☐ Annual Open Enrollment ☐ Address Change
☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Divorce ☐ Death ☐ Birth
☐ Adoption/Legal Custody ☐ Court ordered Dependent ☐ Dependent married/reached age limit
☐ Cobra/State Continuation ☐ Other:

Employee Information

Social Security Number: - -	Date of Birth: / /	
Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:
Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Product Selection

Plan Coverage: ☐ Employee Only ☐ Employee + Spouse (or Domestic Partner) ☐ Employee + Child(ren) ☐ Family

If your Employer offers you a choice of dental plan, please indicate your Plan selection (e.g., Options PPO, Indemnity, DHMO, INO[SM]), and Plan Code (e.g., P1211).

Plan:
Plan Code:

Family Information

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) Dependent Social Security Number	Date of Birth	Sex	Relationship**	Full-time Student
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:
☐ Enroll ☐ Change ☐ Cancel	___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/____	☐ M ☐ F	Dependent	☐ Yes ☐ No School Name:

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

Other Dental Coverage Information

On the day this coverage begins, will you, your Spouse (or Domestic Partner), or any of your Dependents be covered under any other dental plan, policy or contract including another Dental Benefit Providers of California, Inc. dental plan or Medicare? ☐ Yes ☐ No

Spouse (or Domestic Partner) Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:
Dependent Name:	Name of other Carrier:

Primary Dentist Information

Please use the Dental Directory to select a Primary Care Dentist for yourself and each of your covered Dependents

Insured Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Spouse (or Domestic Partner*) Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:
Dependent Name:	Dentist: Existing Patient ☐ Yes ☐ No	ID#:

Employee/Applicant Signature
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Evidence of Coverage. I understand there may be instances where treatment decisions made by my Dentist or me for dental expenses which I have incurred may not be covered by my dental benefit plan.

The Evidence of Coverage provides dental benefits only. Review your Evidence of Coverage carefully.

California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FRAUD WARNING STATEMENT: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits

Employee/Applicant Signature:	Date: / /

To Be Completed by Employer

Employer Name:			Enrollee Effective Date: / /	Class Code:
Enrollment: ☐ New Hire ☐ Other	Date of Hire: / /	Contract Number:	Plan Variation/ Reporting Code:	Plan Code:
Employer Authorization:				

UnitedHealthcare Dental insurance products are underwritten or provided by: Dental Benefit Providers of California, Inc.

DELTA DENTAL

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
2808	1004	CA

Effective Date / / Hire Date / /

Name of Employer: COUNTY OF SOLANO

Location | Pay Code | Benefit Package

Enrollee/Change Information

☒ New Enrollment ☐ Marital Status Change ☐ Terminate Enrollee Coverage ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

☐ Add/Delete Dependent ☐ Address Change ☐ Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	☐ Male ☐ Female	☐ Single ☐ Married

First Name | Last Name | Middle Initial

Mailing Address (Street) | City | State | Zip Code

E-mail Address (internal use only) | Phone Number ( ) - | Phone Type Cell ☐ Work ☐ Home ☐

Name of Other Dental Carrier | Policy Holder Name (first/last) | Date of Birth / /

Effective Date of Other Policy / / | Policy Holder Street Address | City | State | Zip Code

Enrollee Classification

☐ Full-Time ☐ Hourly ☐ Certified
☐ Part-Time ☐ Salaried ☐ Classified
☐ Retired ☐ Member/Other _____

COBRA (if applicable)

☐ Termination
☐ Reduction in Hours
☐ Divorce/Legal Separation*
☐ Widowed/Surviving Dependent*
☐ Dependent Child No Longer Eligible*

Indicate qualifying date: ____/____/____

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	
Dependent		☐ ☐		/ /	☐ ☐	☐ ☐	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

Signature of Enrollee _____ Date ____/____/____

2025

EMPLOYEE ENROLLMENT FORM

Flexible Spending Account (FSA)

Enrollment forms can be scanned to the HRBenAssistants@SolanoCounty.com

Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected.
Return the completed and signed form to your employer for processing.

For Employer to complete where applicable:

Employer Name County of Solano Employer TASC ID # 4800-0443-9980
Employer Class _____ Employer Division _____
Participant Plan Effective Date _____ First Payroll Date _____

INDIVIDUAL/PARTICIPANT INFORMATION

First Name:		MI:		Last Name:			
TASC ID # (if known):		Email Address[1]:					
Primary Phone #:		Mobile Phone #[1]:					
Primary Address:	Address Line 1:				Apt:		
	Address Line 2:						
	City:						
	State:		ZIP/Postal Code:		+4		
Date of Birth:		Hire Date:		Employee ID #			

All fields are required for account setup. Information is confidential and is not used for marketing purposes.
[1]*Please provide this information if available (not required).*

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I select the following benefits and amount(s) to be deducted pretax:	Employee Bi-Weekly Election Amount	Number of Pay Periods	Employee Annual Election
☐ **Healthcare FSA** ($3,300.00 maximum) ☐ I elect to exclude my spouse (for HSA eligibility reasons).	$	$ ____	$
☐ **Dependent Care FSA** Daycare Expenses ($5,000 annual maximum)	$	$ ____	$
☐ **Transit Account** ($3,900 annual - $325 monthly maximum)	$	$ ____	$
☐ **Parking Account** ($3,900 annual - $325 monthly maximum)	$	$ ____	$

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.
To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** **(No fee)**	
2	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	
3	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

***** If you are currently enrolled, do not list a spouse or dependent above that currently have an unexpired TASC Card*****

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

EMPLOYEE ENROLLMENT FORM
Flexible Spending Account (FSA)

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions.

I certify that I will use any debit card that may be provided under this plan only for purposes of healthcare expense reimbursement, dependent care reimbursements, and/or reimbursing expenses that have been incurred for commuting to and from work at my Employer and that, if I receive Transit Passes under the plan, I will not transfer the Pass to anyone else. I understand that if I make false, fictitious, or fraudulent certifications, my employer may take an adverse employment action against me, up to and including termination of employment.

I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature: _____ Date: _____
(please use original signature - no cursive fonts)

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum based on the current IRS limits. Your employer's plan maximum may be less than the IRS maximum. Review your Summary Plan Description (SPD) for your specific plan maximum. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
2. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.
3. **Transit Account Election:** Amount incurred per month to travel to and from work on mass transit facilities, or commuter highway vehicles. Examples of eligible expenses are vouchers, fare cards, or tokens for a bus, train, ferry, subway, or ride-share services (i.e., uberPOOL, Lyft Line, vanpool). Monthly limits apply.
4. **Parking Account Election:** Amount incurred per month for parking expenses at or near your place of employment or at a location from which you commute to work (e.g. ramp or park 'n ride). Monthly limits apply.

IMPORTANT NOTE:
How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

For enrollment assistance: call toll-free 800-422-4661
Have your enrollment form, employer name, and the Client ID# ready.
Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/

Orthodontia Worksheet and Instructions

The treatment of orthodontic expenses under a Medical Flexible Spending Account (FSA) is different than other medical expenses because services generally span more than one Plan Year. Under IRS regulations, the service must be reimbursed from the same FSA Plan Year in which the services were provided and the service must have been incurred. Nevertheless, IRS officials have informally commented that a pre-payment of orthodontia expenses is permissible in certain instances. Below are the various options for reimbursement of orthodontic services, instructions on how to submit a reimbursement request for orthodontic expenses, and instructions on completing the Orthodontia Worksheet.

If a service agreement or contract has been drawn between the orthodontic provider and Participant agreeing on services provided and payments due over the course of the treatment, the Participant is reimbursed on a monthly basis according to the agreement. Reimbursements for these payments may span over one or more FSA Plan Years, as per the agreement. For example, if the agreement indicates a one-time payment of $500 upon placement of the braces and a monthly fee of $50 thereafter for two years, the amounts eligible for reimbursement are those incurred within each Plan Year (up to your current remaining balance). Pre-payments of monthly fees are not reimbursable as the service must be provided and payment must have a due date within your Plan Year coverage period. (Payments due in one Plan Year cannot be reimbursed from the next Plan Year.)

If full payment is required by the orthodontic provider before services can begin, the total cost for the treatment is eligible for reimbursement when the work is started and the payment is made. A one-time reimbursement for the total cost of the treatment up to your current available balance may be made from your current Plan Year Medical FSA. For example, if a full payment of $3,000 is required at time of placement and your current Medical FSA balance is $2,500, you are eligible to be reimbursed for $2,500.

If the orthodontic provider does not offer the options above, complete the Orthodontia Worksheet to determine the monthly amount that may be eligible for reimbursement from your Medical FSA.

Loan payments and interest on a loan are not eligible expenses. Thus, the TASC Card cannot be used to make payments to a loan company. Complete the Orthodontia Worksheet if no other receipt or contract is available from the orthodontic provider.

Submitting orthodontia expenses for reimbursement:

1. A Request for Reimbursement Form must be completed each time you want to be reimbursed.
2. With each Request for Reimbursement, include a copy of the orthodontic contract, coupon (if provided a payment book), or itemized receipt. All documentation must clearly indicate the month and year of the service provided (or payment due date), the monthly payment amount, the name of the provider, and a description of the service (orthodontia, braces, placement, or banding fee).
3. In the absence of a contract or service agreement:
    a. Complete the Orthodontia Worksheet
    b. Have it signed by your orthodontist;
    c. Submit with each Request for Reimbursement.
4. Initial payments, banding, or placement fees are eligible for reimbursement upon placement. An itemized receipt must accompany the Request for Reimbursement Form that indicates the service is a banding or placement fee instead of a monthly fee.

FlexSystem®

5. A Request for Reimbursement of payment in full for orthodontic treatment at the start of the orthodontic services requires an itemized receipt from the orthodontic provider to accompany the Request for Reimbursement.

In the absence of a contract or service agreement, the orthodontic provider must apportion the total cost of the treatment, less the initial payment due and any payments expected from your insurance company or provider discounts, to the remaining number of months required for treatment. This will determine the monthly payment amount eligible for reimbursement from the Medical FSA. Include a **copy** of this completed form with each Request for Reimbursement Form submitted to TASC.

1. Enter the total cost for the duration of the treatment in the *Total Cost* section in below.
2. Enter in any insurance payments and provider discounts.
3. Enter the estimated portion of the total cost that is apportioned to the services provided in the first visit (when the braces are applied) in the *Initial Payment Due* section. (Generally one-third or less of the total cost.)
4. Subtract the insurance payments, provider discounts, and initial payment due from the total cost and enter this amount in the *Total Remaining Balance* section.
5. Enter the number of months the treatment is expected to continue after placement of the braces.
6. Divide the Total Remaining Balance by the number of months and enter this amount in the *Monthly Payment* section. This is the amount eligible for reimbursement from the FSA on a monthly basis.

_____ _____

Participant Name | Participant 12-Digit TASC ID

_____ _____

Employer | Employer 12-Digit TASC ID (optional)

_____ _____

Patient Name | Date Treatment Begins (Mo/Day/Year)

Total Cost for Orthodontia Services: $ _____

Subtractions:

Insurance Payments: $ _____

Provider Discount: $ _____

Initial Payment Due (upon placement of braces): $ _____

Total Remaining Balance: $ _____ /_____ = _____

Number of Months | **Monthly Payment and Eligible Monthly Reimbursable Amount**

_____ _____

Signature of Orthodontic Service Provider | Date

_____

Printed Name of Orthodontic Service Provider

LETTER OF MEDICAL NECESSITY

Include this completed form with your Request for Reimbursement online, or submit via fax or mail:	Fax	Mail
	(608) 663-2762	TASC, P.O. Box 7308 Madison, Wisconsin 53704-7308

SECTION I – PARTICIPANT AUTHORIZATION

Employer Name:		Employer TASC ID:			
First Name:		MI:		Last Name:	
TASC ID:		Email Address:			
Primary Phone:		Mobile Phone:			

The statements in this document are complete and true, to the best of my knowledge and belief. I understand that the IRS regulates my benefit account(s) and that the guidelines are implemented as a means of ensuring compliance with reimbursable expenses and that TASC reserves the right to verify the eligibility of the expenses in accordance with IRS regulations. I further understand that it is my responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible requests.

_____ _____

Participant's Signature **Date**

SECTION II – TREATMENT INFORMATION

To be completed by Medical Practitioner:

Patient Name:				
Prescribed Treatment Product/ Services	**Reason for Treatment/ Medical Condition**	**Instructions/ Restrictions (if applicable)**	**Date of Diagnosis/Onset**	**Duration/No. of Treatments**

I hereby certify that the treatment plan(s) listed above is medically necessary to treat the ailment or medical condition listed above. This treatment plan is neither for cosmetics or general health and well-being.

_____

Medical Practitioner's Printed Name

_____ _____

Medical Practitioner's Signature **Date**

LETTER OF MEDICAL NECESSITY

Use this form to be reimbursed for healthcare products and services that require authorization from a Medical Practitioner to be considered eligible for reimbursement from a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA) or other TASC benefit account.

INSTRUCTIONS

1) Complete the form on the following page:
    a. Complete **Section I** (including your signature and the date) *prior* to visiting your Medical Practitioner.
    b. Bring this form with you to your next medical appointment and request that the attending Medical Practitioner complete **Section II**. Instruct them to follow the specific pharmacy/prescription laws in their respective state when completing Section II.
2) You must submit a copy of this completed form to TASC with each Request for Reimbursement (if submitting online, include a copy with your receipts). Any Letter of Medical Necessity received without a Request for Reimbursement will not be processed.
3) The Letter of Medical Necessity will be considered effective for 12 months from the date signed by the Medical Practitioner, or until the end of the benefit plan year in which it was submitted. A new form must be submitted each plan year in which you request reimbursement, or any time the treatment plan changes.

DEFINITIONS *(for the purposes of this form)*

- "Letter of Medical Necessity" refers to any order for healthcare products or services signed by a licensed Medical Practitioner granted prescriptive authority by the laws of the state. It contains the name and quantity of the medicine/product/service prescribed, directions for use, and treatment duration.
- "Medical Practitioner" generally includes the following licensed health professionals: physician (MD/DO), physician assistant, nurse practitioner, dentist, optometrist and podiatrist.

Products and services that require a Letter of Medical Necessity or other Medical Practitioner authorization to show the expense is to treat a medical condition include the following:

Air Purifier
Varicose Vein Treatment
Special Foods (excess cost only)
Nutritionist's Professional Fees
Exercise Equipment
Automobile Modifications
Whirlpool/Spa
Support Hose
Orthopedic Shoes (excess cost only)
Massage Therapy
Ear Plugs
Wigs

CalPERS Health Monthly Premiums for Contracting Agencies - Region 1

Effective **01/01/25**, the County maximum monthly contribution is:

Units 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 16X, 17, 18, 19, 30, and Unrepresented Managers (Legislative - Unit 60, Executive - Unit 61, and Senior - Unit 62) is $2,314.83

Extra Help Units **00, 82, 87, 89, and 90** is **$1,851.86**

Employees who elect **Employee Only** coverage, will receive no more than **$334.58** per month as cash back.

Employees who **Waive** coverage will receive no more than **$342.00** per month as cash back.

Contributions are subject to change if a new/successor MOU is ratified with changes to County contribution

Bargaining Units **1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 16X, 17, 18, 19, 30, and Unrepresented Managers (Legislative - Unit 60, Executive - Unit 61, and Senior - Unit 62)** who elect **Employee Plus Two or More Coverage** receive a **$50.00/month** supplemental County contribution into the cafeteria plan.

	2025 (Region #1)						2024 (Region #1)					
Plan	**Single**	**Plan Code**	**2-Party**	**Plan Code**	**Family**	**Plan Code**	**Single**	**Plan Code**	**2-Party**	**Plan Code**	**Family**	**Plan Code**
Anthem HMO Select *	$ 1,256.65	**5061**	$2,513.30	**5062**	$ 3,267.29	**5063**	$ 1,138.86	**5061**	$ 2,277.72	**5062**	$ 2,961.04	**5063**
Anthem HMO Traditional	$ 1,500.40	**5091**	$ 3,000.80	**5092**	$ 3,901.04	**5093**	$ 1,339.70	**5091**	$ 2,679.40	**5092**	$ 3,483.22	**5093**
Anthem EPO Del Norte *	N/A		N/A		N/A		$ 1,314.27	**5041**	$ 2,628.54	**5042**	$ 3,417.10	**5043**
Blue Shield Access+ HMO	$ 1,170.17	**5251**	$ 2,340.34	**5252**	$ 3,042.44	**5253**	$ 1,076.84	**5251**	$ 2,153.68	**5252**	$ 2,799.78	**5253**
Blue Shield Trio * HMO	$ 1,134.79	**4511**	$ 2,269.58	**4512**	$ 2,950.45	**4513**	$ 946.84	**4511**	$ 1,893.68	**4512**	$ 2,461.78	**4513**
Kaiser Permanente	$ 1,112.90	**5331**	$ 2,225.80	**5332**	$ 2,893.54	**5333**	$ 1,021.41	**5331**	$ 2,042.82	**5332**	$ 2,655.67	**5333**
UnitedHealthcare Alliance	$ 1,184.58	**5761**	$ 2,369.16	**5762**	$ 3,079.91	**5763**	$ 1,091.13	**5761**	$ 2,182.26	**5762**	$ 2,836.94	**5763**
UnitedHealthcare Harmony **	$ 1,005.02	**4951**	$ 2,010.04	**4952**	$ 2,613.05	**4953**	$ 937.39	**4951**	$ 1,874.78	**4952**	$ 2,437.21	**4953**
Western Health Advantage HMO	$ 914.27	**5911**	$ 1,828.54	**5912**	$ 2,377.10	**5913**	$ 807.23	**5911**	$ 1,614.46	**5912**	$ 2,098.80	**5913**
PERS Gold PPO	$ 1,013.70	**6481**	$ 2,027.40	**6482**	$ 2,635.62	**6483**	$ 914.82	**6131**	$ 1,829.64	**6132**	$ 2,378.53	**6133**
PERS Platinum PPO	$ 1,476.10	**6571**	$ 2,952.20	**6572**	$ 3,837.86	**6573**	$ 1,314.27	**6011**	$ 2,628.54	**6012**	$ 3,417.10	**6013**
PORAC	$ 975.00	**5921**	$ 2,218.00	**5922**	$ 2,777.00	**5923**	$ 931.00	**5921**	$ 2,117.00	**5922**	$ 2,651.00	**5923**

**** Plan not available in Solano County***

Anthem HMO Select is available in Alameda, Contra Costa, El Dorado, Monterey, Placer, Sacramento, San Francisco, San Joaquin, Santa Clara, Santa Cruz, and Stanislaus Counties
Anthem EPO Del Norte is only available in Del Norte **County**
Blue Shield Access+ is NOT available in Napa County
Blue Shield Trio is only available in Butte, Contra Costa, El Dorado, Kern, Kings, Monterey, Nevada, Placer, Sacramento, Santa Cruz, Shasta, Stanislaus, Tulare, and Yolo Counties
Blue Shield EPO is only available in Alpine, Calaveras, Colusa, Inyo, Lake, Lassen, Mendocino, Modoc, Mono, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne Counties
UnitedHealthcare SignatueValue Alliance is available in Alameda, Contra Costa, El Dorado, Marin, Merced, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, **Solano**, Sonoma, Stanislaus, and Yolo Counties
UnitedHealthcare SignatureValue Harmony ** is **only** available in Contra Costa, Napa, Santa Clara, Santa Cruz, and Solano (zip codes 94510 and 94591) Counties
Western Health Advantage is available in El Dorado, Humboldt, Marin, Napa, Placer, Sacramento, **Solano**, Sonoma, and Yolo Counties

COUNTY OF SOLANO
EMPLOYEE BENEFIT WAIVER FORM

PRINT NAME_____ **SSN**_____ **DATE**_____

DEPARTMENT_____ **WORK %**_____ **DATE OF HIRE**_____

FULL-TIME EMPLOYEES COMPLETE:

You must enroll in dental, vision, and life insurance since premiums are 100% paid by the County. Additionally, full-time management employees must enroll in long term disability. You have the option to waive medical coverage only.

☐ **I am not waiving any medical, dental, vision, and life coverage.**

MEDICAL

☐ I have reviewed my options for medical coverage through Solano County and ***DO NOT*** wish to participate in the County's medical plan at this time. I understand that this benefit will not be available to me until the next open enrollment unless I notify the County within 30 days of loss of other medical coverage.

PART-TIME EMPLOYEES COMPLETE:

Part-time employees must pay a portion of the premiums; therefore, part-time employees have the option of waiving coverage.

☐ **I am not waiving any medical, dental, vision, and life coverage.**

MEDICAL

☐ I have reviewed my options for medical coverage through Solano County and ***DO NOT*** wish to participate in the County's medical plan at this time. I understand that this benefit will not be available to me until the next open enrollment unless I notify the County within 30 days of loss of other medical coverage.

DENTAL

☐ I have reviewed my options for dental coverage through Solano County and ***DO NOT*** wish to participate in the County's dental program at this time. I understand that this benefit will not be available to me until the next open enrollment unless I notify the County within 30 days of loss of other dental coverage.

VISION

☐ I have reviewed my options for vision coverage through Solano County and ***DO NOT*** wish to participate in the County's vision program at this time. I understand that this benefit will not be available to me until the next open enrollment unless I notify the County within 30 days of loss of other vision coverage.

LIFE INSURANCE

☐ I have reviewed my options for life insurance coverage through Solano County and ***DO NOT*** wish to participate in the County's life insurance program at this time. I understand that this benefit will not be available to me until the next open enrollment.

EMPLOYEE SIGNATURE_____ **Work Phone**_____

COUNTY OF SOLANO
PERS MEDICAL BENEFIT (PMB) ELIGIBILITY FORM

PRINT NAME_____ **SSN**_____

DEPARTMENT_____

WORK NUMBER_____

I have reviewed my options for CalPERS medical coverage through Solano County and have decided not to participate in the County's medical plan at this time. In lieu of this coverage, I elect to continue to waive the medical plan options, because I have other non-individual market coverage that is minimum essential coverage* through another health insurance plan. I understand that because I am waiving medical coverage, I am now eligible to participate in the Cafeteria Plan and receive cash back money as taxable income. I understand the cash benefit would be received in the same month of eligibility. I certify under penalty of perjury that the provided proof of other medical coverage is true and accurate.

If the status of my other medical coverage changes, I must provide Human Resources the new proof of insurance within 31 days. My failure to notify Solano County may result in owing the County for any monies for which I was not eligible.

I understand that Medi-Cal is not considered proof of other coverage, since Medi-Cal is a Welfare Benefit Program. (California Codes-Welfare and Institutions Code, Section 14000-15000)

EMPLOYEE SIGNATURE_____ **DATE**_____

***Minimum Essential Coverage means**: Plan has an "Actuarial Value" of 60% or more and covers 10 Essential Health Benefits (1. Laboratory Services, 2. Emergency Services, 3. Prescription Drugs, 4. Mental Health & Substance Abuse Disorder Services, 5. Maternity & Newborn Care, 6. Pediatric Services Including Oral & Vision Care, 7. Rehabilitative & Habilitative Services & Devices, 8. Ambulatory Patient Services, 9. Preventive & Wellness Services & Chronic Disease Management, and 10. Hospitalization)

Health Benefits Plan Enrollment for Active Employees (HBD-12)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

SECTION A: Applicant Information

1. Employee Name: *(First)* *(M.I.)* *(Last)*

2. Hire Date: (mm/dd/yyyy)

3. CalPERS ID or Social Security Number:

4. Date of Birth: *(mm/dd/yyyy)*

5. Gender: ☐ Male ☐ Female ☐ Nonbinary

6. Physical Address: *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

7. Mailing Address (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*

8. Use Work ZIP Code for Health Eligibility: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*

9. E-mail Address:

10. Primary Phone: **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☒ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:

13. Permitting Event Date: (mm/dd/yyyy)

14. Name of Health Plan: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 **Relationship Codes:** **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. To enroll, carefully review the information in this section and check the box:

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

17. To decline, carefully review the information in this section and check the box:

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. Employee Signature:

19. Date: *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. Agency Name: County of Solano	**21. Date of Hire:** *(mm/dd/yyyy)*	**22. Retirement System:** ☒ CalPERS ☐ CalSTRS ☐ Other
23. CalPERS Employer ID: 7688821115	**24. Division ID:**	**25. Employee Bargaining Unit/Employee Group:**
26. Payroll Office: ☐ State Controller's Office ☐ Non Central ☒ Public Agency Billing	**27. Date Received by Employer:**	**28 Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. Health Benefits Officer: (Print name)	**30. Signature:**	**31. Date:** *(mm/dd/yyyy)*	**32. Phone Number:**

33. Remarks:

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name: _____

Employee ID#: _____

Employer Name: _____

Employer ID#: _____

Your earnings from this job are not covered under Social Security (i.e., you will not pay Social Security taxes). This means that you will not earn credits for Social Security retirement or disability benefits in this job. If you retire or become disabled, and you are eligible for a Social Security benefit based on other work, your earnings from this job will not be used to compute your Social Security benefit. In addition, we will not consider these non-covered earnings for the future potential calculation of survivor benefits based on your earnings. Your earnings from this job are subject to Medicare taxes and will count for purposes of the Medicare program. For information on how you may qualify for Social Security benefits, visit www.ssa.gov.

For More Information

Social Security publications and additional information are available at www.ssa.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

I certify that I have received Form SSA-1945 and understand that my earnings from this job are not covered under Social Security and will not be used to determine eligibility to or the amount of my potential future Social Security Benefits.

Signature of Employee: _____

Date: _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

The Social Security Protection Act of 2004, Pub. L. No. 108-203, Section 419 requires State and local government employers to provide a statement to employees hired January 1, 2005, or later in a job not covered under Social Security. Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers must use to meet the requirements of the law.

While the earlier version of the SSA-1945 discussed the effect of the Windfall Elimination Provision and/or Government Pension Offset on an employee's potential future benefits, the Social Security Fairness Act (SSFA) of 2023 enacted on January 5, 2025, eliminated the reduction of Social Security benefits under the Windfall Elimination Provision and/or Government Pension Offset for individuals entitled to certain pensions from work not covered by Social Security, starting January 2024. However, this did not remove the requirement for State and local government employers to provide a statement to employees hired January 1, 2005, or later in jobs not covered under Social Security. This version of SSA-1945 explains to an employee that non-covered earnings will not be used to determine eligibility to or calculate the amount of potential future benefits.

Employers must:

- Get the employee's signature on the form
- Give the signed statement and information page to the employee prior to the start of employment
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

A fillable, downloadable version of the SSA-1945 is available online at the Social Security website, www.ssa.gov/online/ssa-1945.pdf.

P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | Fax: (800) 959-6545
TTY: (877) 249-7442
www.calpers.ca.gov

California Public Employees' Retirement System

Pre-Retirement Lump-Sum Beneficiary Designation

Complete this form if you are currently employed (active) or an inactive member and you wish to designate a beneficiary or change your existing beneficiary designation for lump-sum benefits. Please print clearly. We are unable to process this form if there are erasures or corrections. See the information and instructions page for more detailed information.

Section 1 — Information About You

Please provide your name as it appears on your Social Security card.

Your Name (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

( ) Daytime Phone | ( ) Alternate Phone

Address

City | State | ZIP

Section 2 — Your Primary Beneficiary Information

Please see the last page of this form for information on your pre-retirement benefits and instructions on how to name more than four primary beneficiaries.

If a percentage (%) is entered, make sure the total equals 100%.

Name of Primary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | % Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Name of Primary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | % Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Name of Primary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | % Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 2, cont.

Your Primary Beneficiary Information

Name of Primary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Section 3

Your Secondary Beneficiary Information

Please see the last page of this form for instructions on how to name more than three secondary beneficiaries.

Name of Secondary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

If a percentage (%) is entered, make sure the total equals 100%.

Name of Secondary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Name of Secondary Beneficiary (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy)

Relationship to You | Percentage of Benefit | Social Security Number or CalPERS ID

Address

City | State | ZIP

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 4

Spousal Consent to Beneficiary Designation

You must review and sign this acknowledgment if you are married or in a registered domestic partnership and you name someone other than your spouse or domestic partner as a beneficiary to receive any lump-sum benefits which may be payable upon your death.

Member Acknowledgment

I understand that if I am married or in a registered domestic partnership, my spouse or domestic partner may have community property rights in the following benefit (if applicable):

- The group term life insurance benefit
- The employer share benefit
- The return of any remaining member contributions

If I name someone other than my spouse or domestic partner as my beneficiary for some or all of these benefits and I die before my spouse or domestic partner, he or she may still be entitled to receive his or her community property share of the benefit(s). If I name one or more other individuals as my beneficiary(ies) to receive a benefit listed above, and my spouse or domestic partner does not consent at this time by signing below, CalPERS will award fifty percent (50%) of the community property share of such benefit to my spouse or domestic partner in the event of my death unless he or she waives his or her community property interest in such benefit at the time the benefit becomes payable, and CalPERS will award the remaining fifty percent (50%) of the community property share, plus any separate property share, of such benefit to the named beneficiary(ies).

Your Signature | Date (mm/dd/yyyy)

Spouse's or Registered Domestic Partner's Consent

I hereby voluntarily and irrevocably consent to each of the beneficiary designation(s) by my spouse/registered domestic partner on this form. I acknowledge and understand that I am not obligated to consent and, if I do consent, and my spouse or registered domestic partner dies before me and has named a beneficiary other than me, some or all the following benefit will be paid to a beneficiary other than me in accordance with the beneficiary designation(s):

- The group term life insurance benefit
- The employer share benefit
- The return of any remaining member contributions

Your spouse or registered domestic partner should sign this consent if he or she consents to each of your beneficiary designations after reviewing this section.

I understand that I may have community property or other rights in these benefits and I hereby voluntarily waive and release any rights I may have to these benefits. I understand that I do not have to sign this consent and that if I do sign my consent is irrevocable. I acknowledge that I have received a complete explanation of each benefit listed above (if applicable) and I have had the opportunity to consult with an attorney or other professional concerning this waiver.

Your Spouse's or Domestic Partner's Signature | Date (mm/dd/yyyy)

Put your name and Social Security number or CalPERS ID at the top of every page.

Your Name | Social Security Number or CalPERS ID

Section 5

Your Signature

Before submitting your completed form, be sure to make a copy to keep with your important retirement information.

By this beneficiary designation, I hereby revoke any previous designation I have filed. I understand that my marriage or domestic partnership, final dissolution or annulment of my marriage or the termination of my domestic partnership, or the birth or adoption of a child subsequent to the date this form is filed with CalPERS will automatically void this designation. I understand that a designation filed **after** the initiation of dissolution or annulment of marriage or domestic partnership or legal termination of domestic partnership will **not** be revoked when the legal process is finalized.

Are you legally married or in a registered domestic partnership? ○ Yes ○ No

If no, please indicate: ○ Never Married or in Domestic Partnership

○ Divorced, Annulled, or Domestic Partnership Terminated

○ Widowed

If you answered yes above, your spouse or registered domestic partner must sign this beneficiary designation unless you have designated him or her as the sole primary beneficiary of any lump-sum benefits. Otherwise, you must complete and submit the ***Justification for Absence of Spouse's or Registered Domestic Partner's Signature*** form.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge.

Your Signature | Date (mm/dd/yyyy)

Section 6

Your Spouse's or Registered Domestic Partner's Signature

Per Government Code section 21261, I acknowledge that I am aware of the designation made by my spouse or registered domestic partner. I also hereby state that I am the current spouse or registered domestic partner.

Signature of Spouse or Registered Domestic Partner | Date (mm/dd/yyyy)

Date of Marriage or Registered Domestic Partnership (mm/dd/yyyy)

Mail to:

CalPERS Retirement Benefit Services Division
P.O. Box 942711, Sacramento, CA 94229-2711
Or fax to: (800) 959-6545

Pre-Retirement Lump-Sum Beneficiary Designation Information

Information

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific benefits to your surviving beneficiaries. Please order or download your member benefit publication from our website at **www.calpers.ca.gov,** or see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a state member with at least 20 years of state service credit, a monthly survivor allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/ registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

   If you do have a valid beneficiary designation on file, your spouse/registered domestic partner may still be entitled to a community property share of your lump-sum contributions or monthly survivor allowance. However, your non-spouse/non-registered domestic partner designated beneficiaries will receive the portion of your lump-sum benefits that are not payable to your spouse/registered domestic partner as his/her community property share.

C. If A and B do not apply and there is no valid beneficiary designation on file at the time of death, the benefits will be payable to your survivors in the following order:

   1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or if none,
   2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or if none,
   3. Parents, share and share alike; or if none,
   4. Brothers and sisters, share and share alike; or if none,
   5. Your estate (if probated, or subject to probate); or if not,
   6. Your trust (if one exists); or if not,
   7. Stepchildren, share and share alike; or if none,
   8. Grandchildren, including step-grandchildren, share and share alike; or if none,
   9. Nieces and nephews, share and share alike; or if none,
   10. Great-grandchildren, share and share alike; or if none,
   11. Cousins, share and share alike

   If A and B do not apply and there is a valid beneficiary designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/registered domestic partner may still be entitled to a community property share of your lump-sum benefits.**

D. You may designate or change your beneficiaries at any time by completing another ***Pre-Retirement Lump-Sum Beneficiary Designation*** form. You may name as beneficiary any person or persons, a corporation, or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: **If you are married or in a registered domestic partnership at the time of your death and you do not name your spouse/ registered domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump-sum benefits or a share of any monthly survivor allowance that may be payable.**

E. Your beneficiary designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:

   1. Your marriage or registration of domestic partnership
   2. The initiation of a dissolution or annulment of your marriage or of a legal termination of your registered domestic partnership (However, a designation filed after the initiation of a dissolution/annulment of a marriage or of a termination of registered domestic partnership is NOT revoked when the dissolution/annulment/termination is finalized.)
   3. The birth of your child or your adoption of a child
   4. A termination of membership that results in a refund of your contributions

Pre-Retirement Lump-Sum Beneficiary Designation Information

Section 1

Information About You

- Complete all fields.

Section 2

Your Primary Beneficiary Information

- To name additional primary beneficiaries, attach a blank sheet of paper with your additional beneficiary information. Provide the same beneficiary information as required on this form, and be sure to indicate that the beneficiary is primary. Sign and date the paper, and include your Social Security number or CalPERS ID.

Section 3

Your Secondary Beneficiary Information

- The benefit is paid to your named secondary beneficiary or beneficiaries upon the death of your primary beneficiary or beneficiaries.
- To name additional secondary beneficiaries, attach a blank sheet of paper with your additional beneficiary information. Provide the same beneficiary information as required on this form, and be sure to indicate that the beneficiary is secondary. Sign and date the paper, and include your Social Security number or CalPERS ID.

Section 4

Spousal Consent to Beneficiary Designation

- If you did not name your spouse or registered domestic partner as your lump-sum beneficiary,you must read and sign the **Member Acknowledgment.** Your spouse or registered domestic partner **must** read the **Spouse's or Registered Domestic Partner's Consent.**

Section 5

Your Signature

- Indicate if you are married or have a registered domestic partner.
- Sign in the required field.

Section 6

Your Spouse's or Registered Domestic Partner's Signature

- Your spouse or registered domestic partner must sign if you did not designate him or her as the sole primary beneficiary for any lump-sum benefits.
- You must complete a ***Justification for Absence of Spouse's or Registered Domestic Partner's Signature*** form if your spouse or registered domestic partner is unable to sign this form. You can print this form from **www.calpers.ca.gov** or call **888 CalPERS** (or **888**-225-7377).

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).