Dependent Eligibility Verification Audit (DEVA)
How to Drop an Ineligible Dependent

Follow the step-by-step instructions below to **drop your ineligible dependent** online.

To learn more about DEVA, visit sfhss.org/deva.

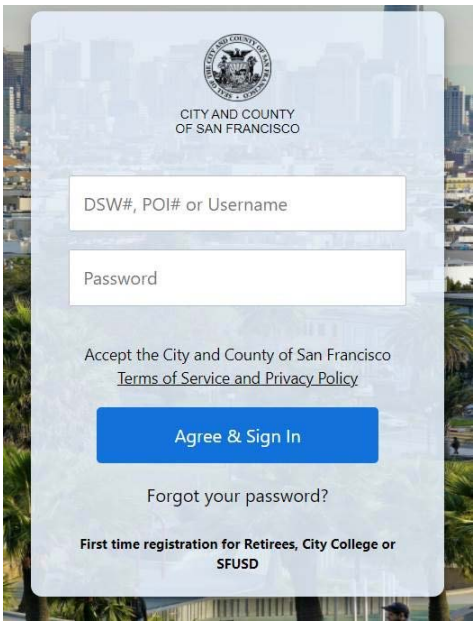
- **How long do I have to respond?** Please refer to your Notification Letter for the deadline to submit your verification documentation, which you received in the mail. If you have any questions about the deadline to submit documentation, please contact SFHSS at **(628) 652-4700**.

- **Problems logging in? Need to reset your password?** If you experience technical issues accessing your account and cannot resolve with our online resources or need to reset your password, call SFHSS at **(628) 652-4700**.

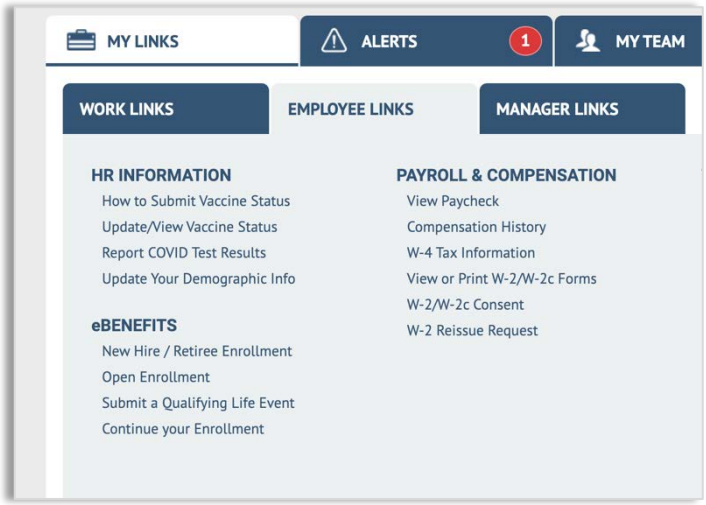
- **How do I drop my ineligible dependent?** You can drop your dependent online by following the instructions below. You can also drop your dependent by completing an Enrollment Form and submitting it by fax or mail. Enrollment Forms can be downloaded at **sfhss.org**. Our **fax number** is (628) 652-4701 and our **mailing address** is SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103.

- You can also drop your documentation off in our secure **Drop Box** located on the 3rd floor from Monday to Friday from 9am to 5pm. Our offices are currently closed to the public.

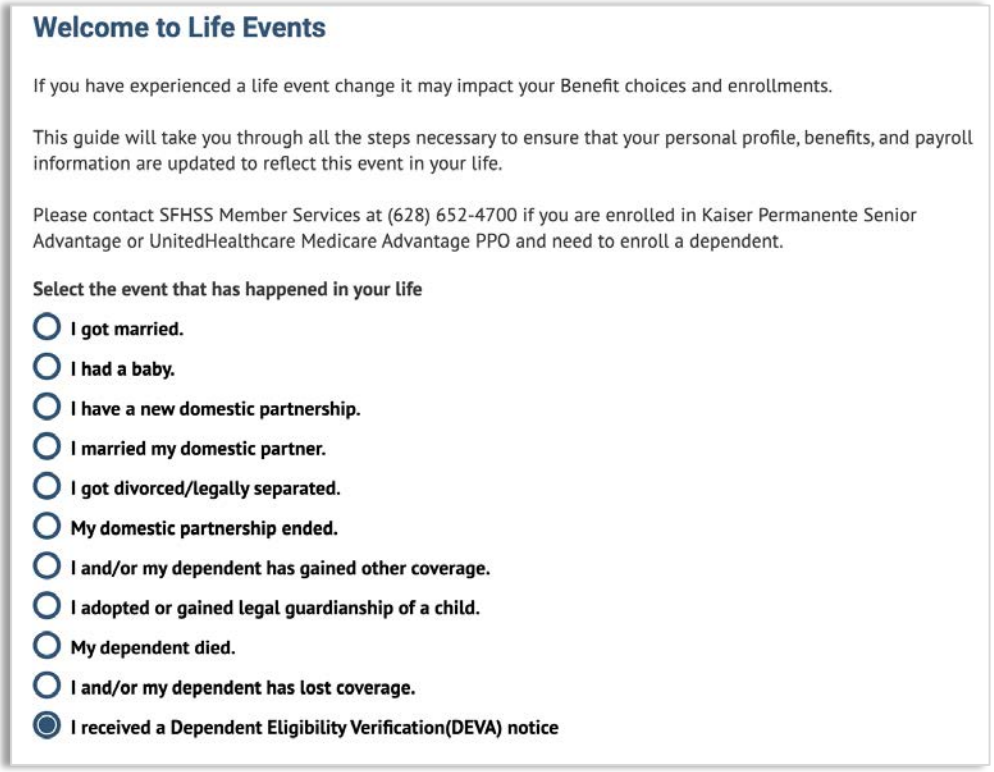
Let's Get Started



1. Go to the San Francisco Employee Gateway https://myapps.sfgov.org/ccsfportal/signin Click on the **San Francisco Employee Portal icon**.
2. Enter your Employee ID and password. Click **Agree & Sign In**.
3. Complete the security verification and click **Verify**.
4. If you are a Retiree and have not previously registered for an account, click on **"First time registration for Retirees, City College or SFUSD."** If you would like step by step instructions on how to Register Your Account (one-time only), visit sfhss.org/deva.



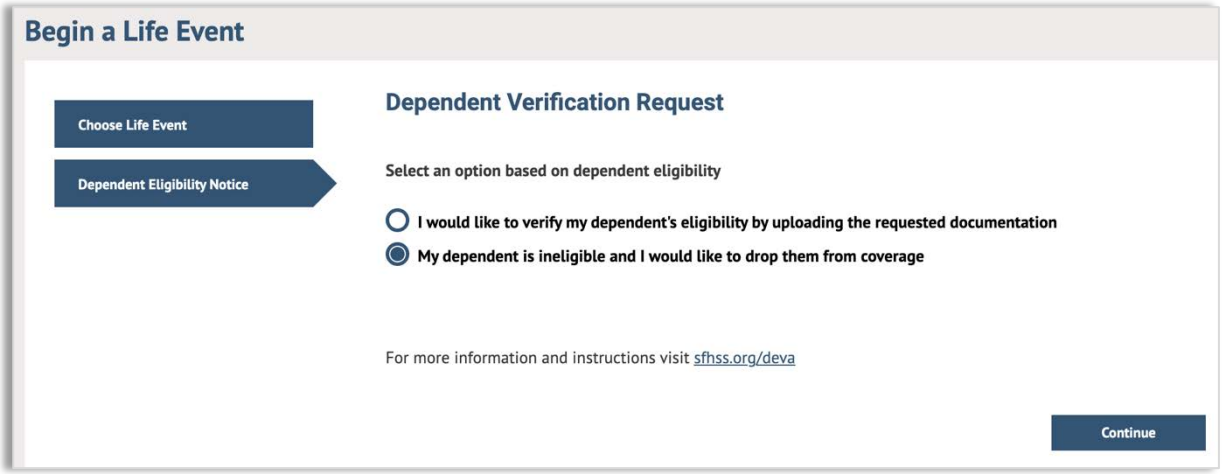
5. Under the *Employee Links* tab (under the *My Links* tab), click on **Submit a Qualifying Life Event**.



6. Select **"I received a DEVA notice"** at the bottom of the list.

7. Click the **Continue** button. 

Begin a Life Event – Dependent Verification Request

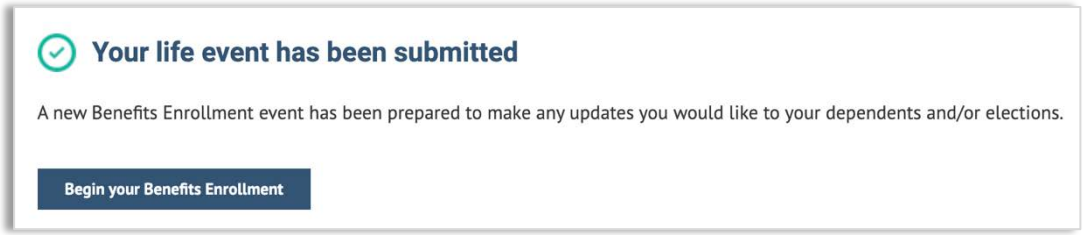


8. Select, **"My dependent is ineligible and I would like to drop them from coverage."**

9. Click **Continue**.

Your Life Event Has Been Submitted

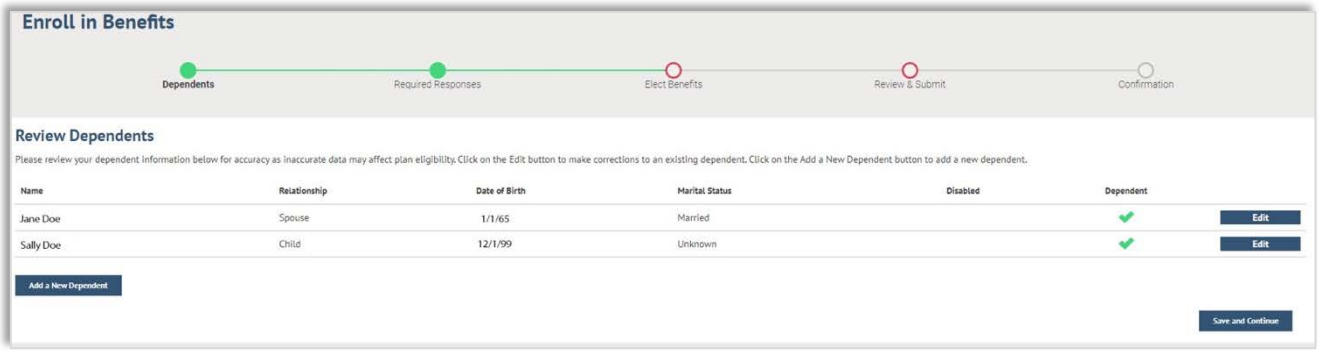
10. After you click **Continue**, your screen will automatically begin processing a life event and your screen should read, "**Your life event has been submitted**."



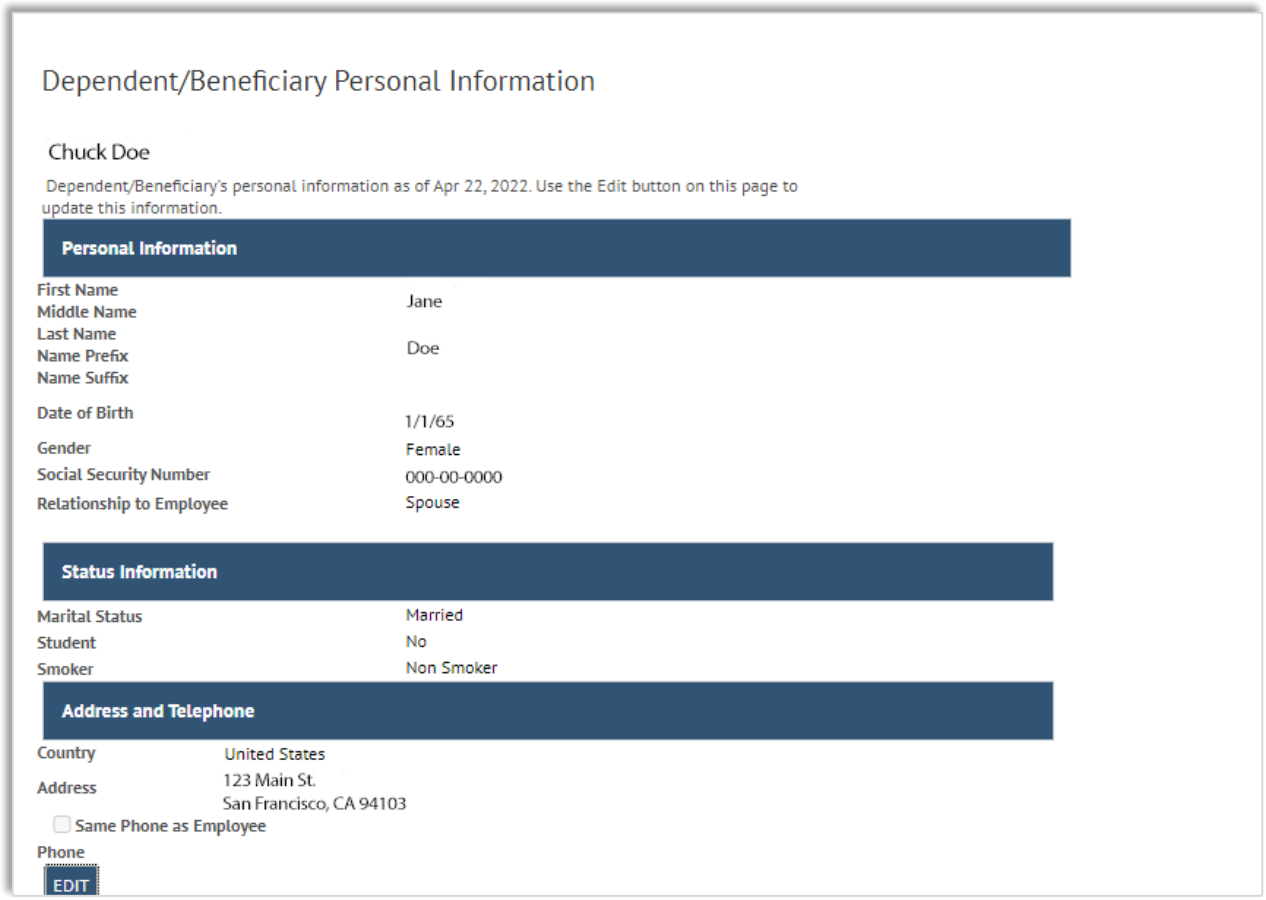
You can now begin the process of disenrolling your ineligible dependent from your existing benefit plan enrollment.

11. Click on the "**Begin your Benefits Enrollment"** button to continue.

Enroll in Benefits



12. Click on the **Edit** button next to the ineligible spouse or domestic partner you wish to dis-enroll from your benefits.



Dependent/Beneficiary Personal Information

Chuck Doe

Dependent/Beneficiary's personal information as of Apr 22, 2022. Use the Edit button on this page to update this information.

Personal Information

First Name	Jane
Middle Name	
Last Name	Doe
Name Prefix	
Name Suffix	
Date of Birth	1/1/65
Gender	Female
Social Security Number	000-00-0000
Relationship to Employee	Spouse

Status Information

Marital Status	Married
Student	No
Smoker	Non Smoker

Address and Telephone

Country	United States
Address	123 Main St. San Francisco, CA 94103

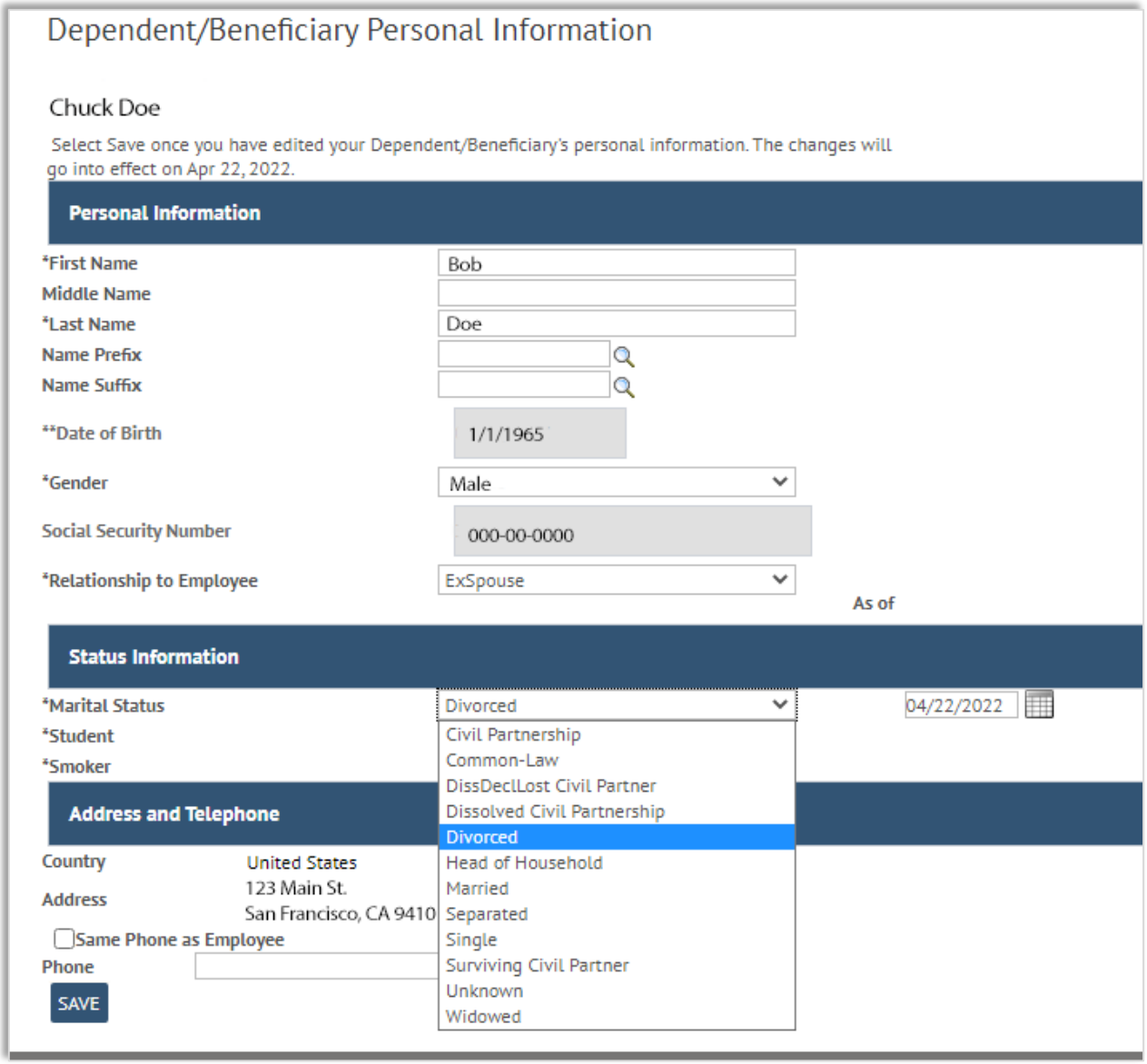
☐ Same Phone as Employee

Phone

EDIT

13. You will need to update TWO items on the **"Dependent/Beneficiary Personal Information"** page:

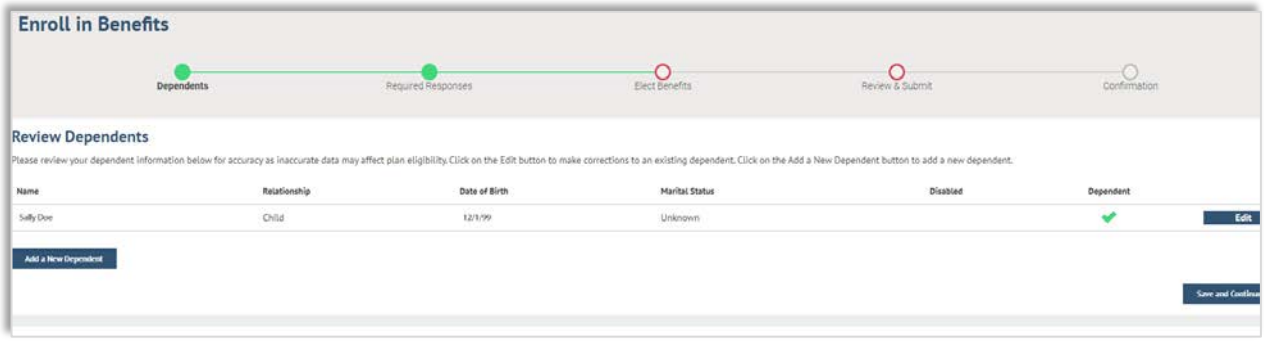
    1. Relationship to Employee
    2. Marital Status



14. Click on the **Edit** button. Next, click on the dropdown menu under **"Relationship to Employee"** and select either **"ExSpouse"** or **"ExDomestic Partner."**

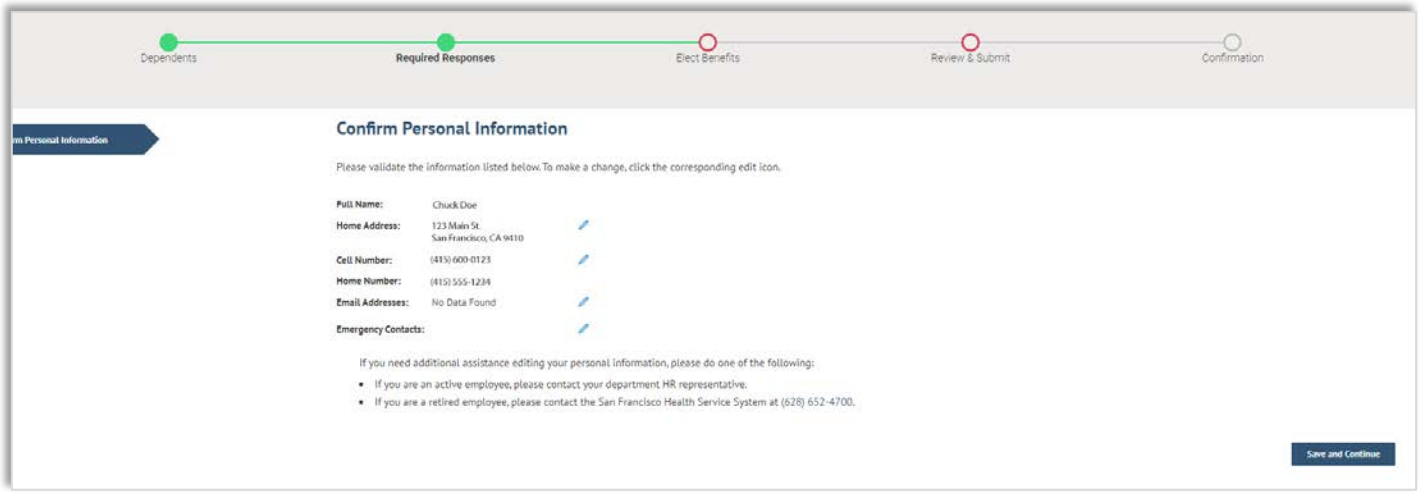
15. Then click on "**Marital Status"** and select the current status of your relationship with your ineligible dependent.

16. Hit the **Save** button to continue.



17. After saving, you should no longer see your ex-spouse or ex-domestic partner listed as a dependent.

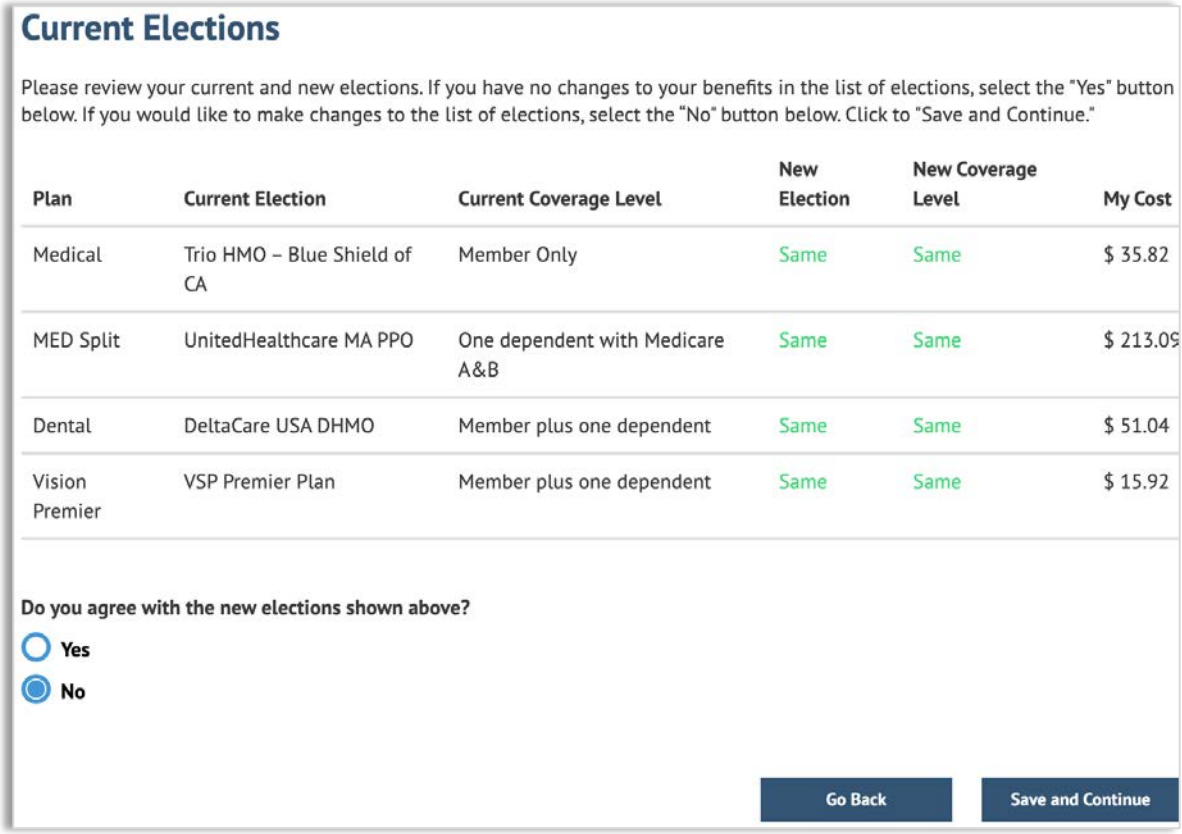
Confirm Personal Information



18. If your ineligible dependent is no longer your **"Emergency Contact,"** please update this page and click on the **Save and Continue** button.

Current Elections

19. Next, you will begin going through your current benefit elections, where **you will need to dis-enroll your ineligible dependent** from your medical, dental, and/or Vision Premier health plan coverage.



Current Elections

Please review your current and new elections. If you have no changes to your benefits in the list of elections, select the "Yes" button below. If you would like to make changes to the list of elections, select the "No" button below. Click to "Save and Continue."

Plan	Current Election	Current Coverage Level	New Election	New Coverage Level	My Cost
Medical	Trio HMO – Blue Shield of CA	Member Only	Same	Same	$ 35.82
MED Split	UnitedHealthcare MA PPO	One dependent with Medicare A&B	Same	Same	$ 213.09
Dental	DeltaCare USA DHMO	Member plus one dependent	Same	Same	$ 51.04
Vision Premier	VSP Premier Plan	Member plus one dependent	Same	Same	$ 15.92

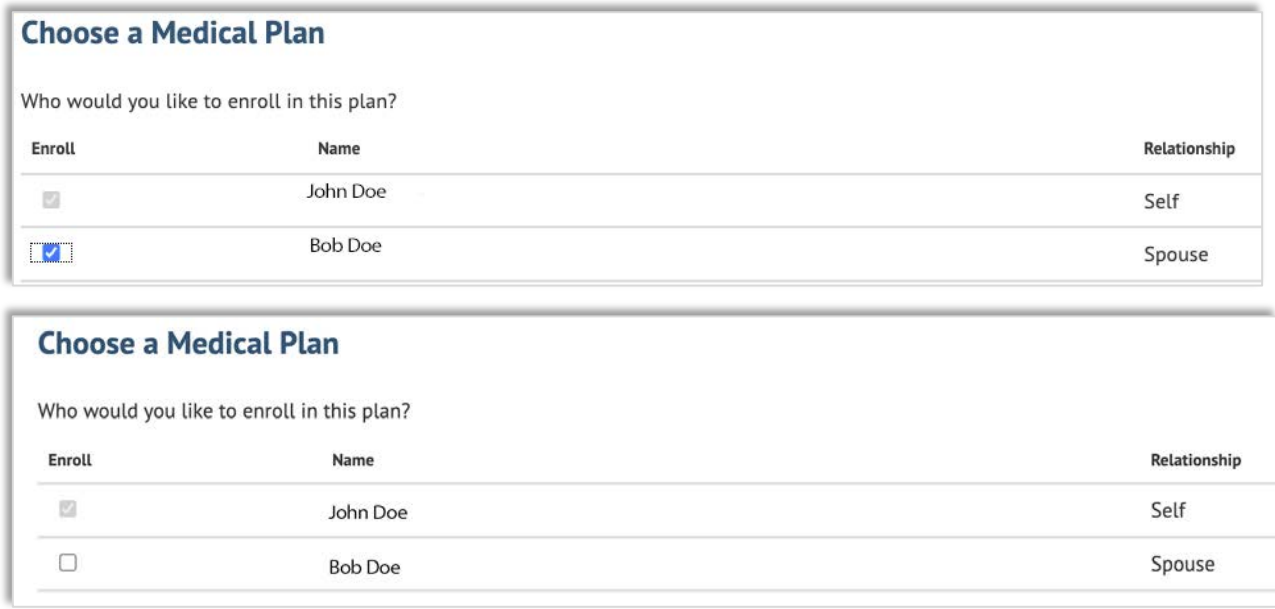
Do you agree with the new elections shown above?

- ○ **Yes**
- ◉ **No**

Go Back | Save and Continue

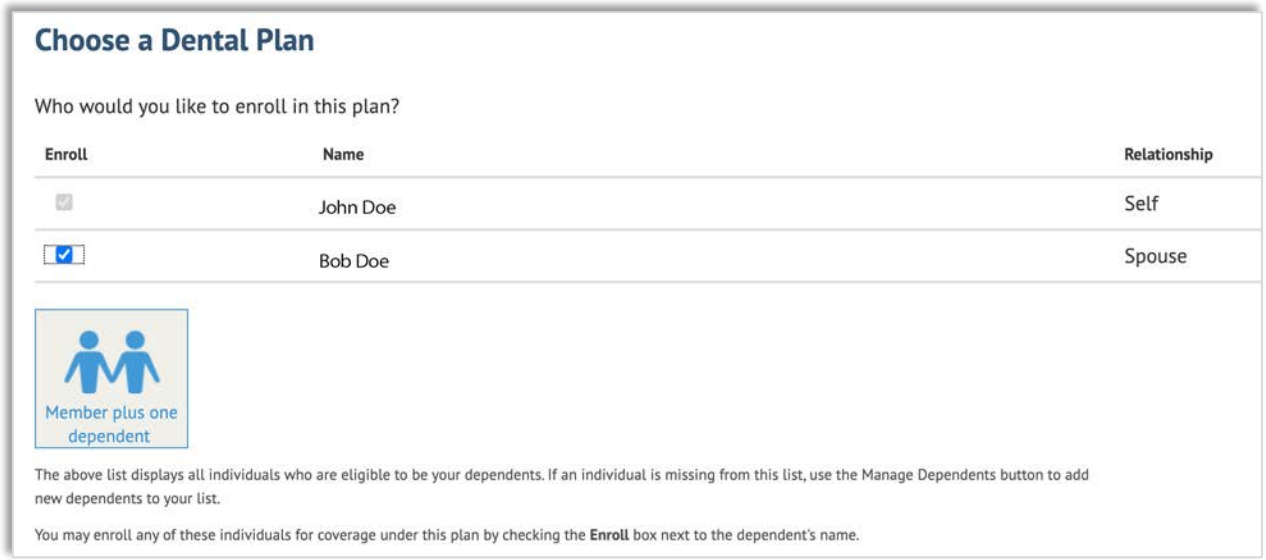
20. Select **"No"** under the question, "**Do you agree with the new elections shown above?"** Click the **"Save and Continue"** button.

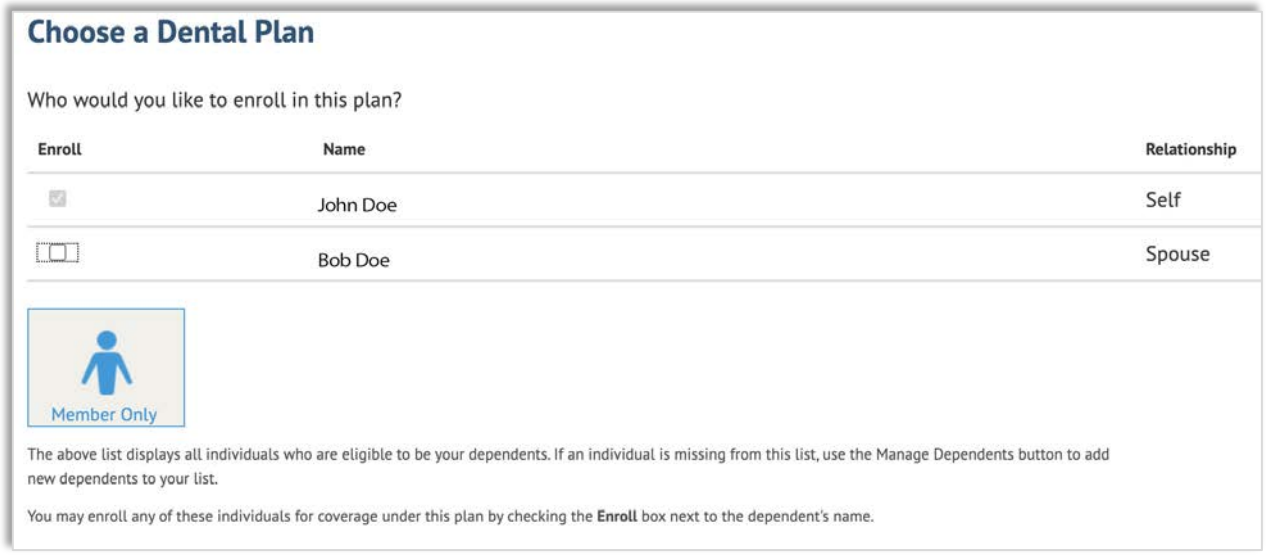
Choose a Medical Plan



21. Disenroll your ineligible dependent by deselecting the box under ***Enroll*** next to your ineligible dependent's name. Click the **"Save and Continue"** button.

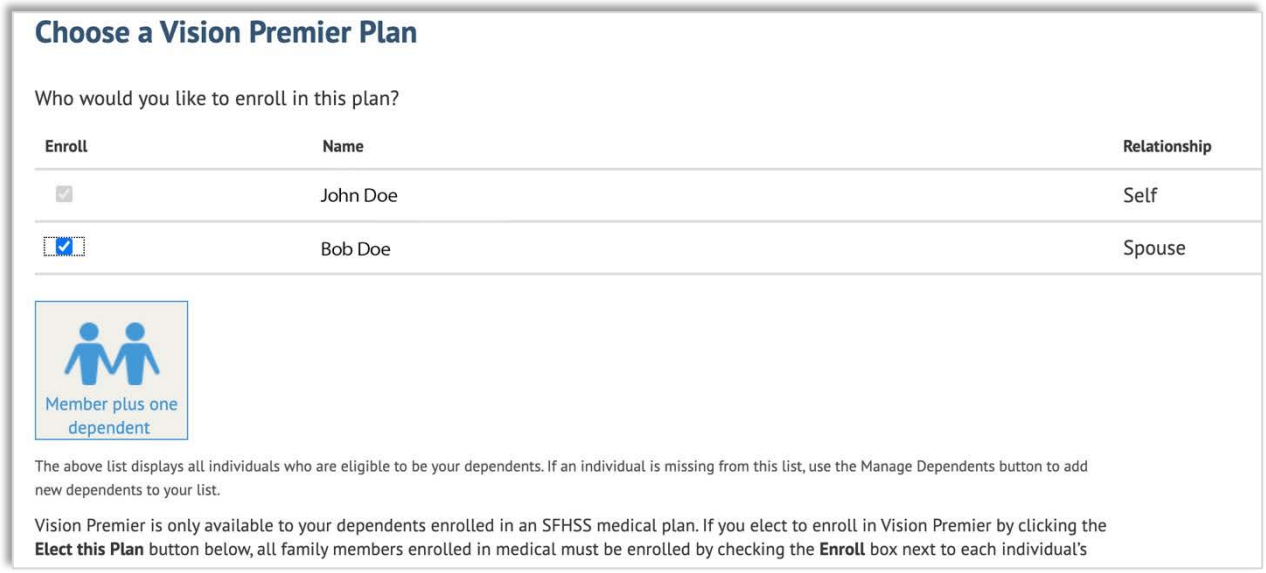
Choose a Dental Plan

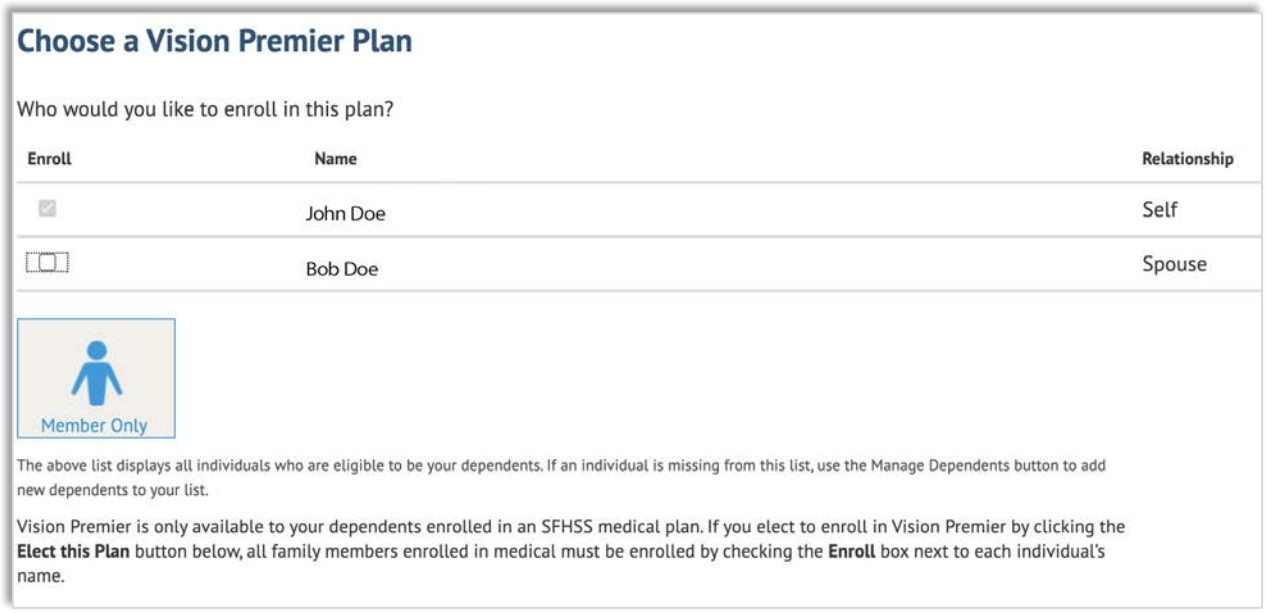




22. Disenroll your ineligible dependent by deselecting the box under ***Enroll*** next to your ineligible dependent's name. Click the **"Save and Continue"** button.

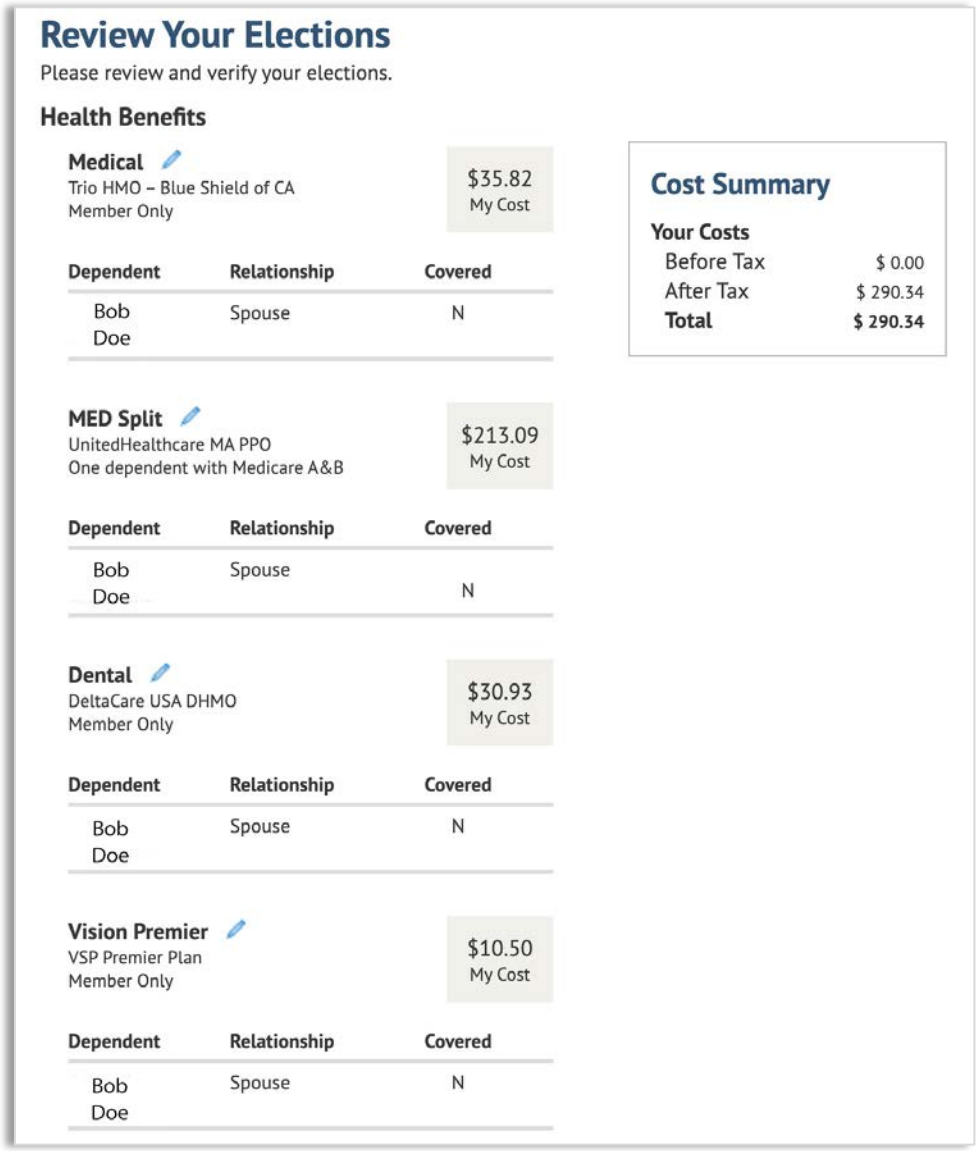
Choose a Vision Premier Plan





23. Disenroll your ineligible dependent by deselecting the box under ***Enroll*** next to your ineligible dependent's name. Click the **"Save and Continue"** button.

Review Your Elections



Review Your Elections

Please review and verify your elections.

Health Benefits

Medical
Trio HMO – Blue Shield of CA
Member Only
$35.82
My Cost

Dependent	Relationship	Covered
Bob Doe	Spouse	N

MED Split
UnitedHealthcare MA PPO
One dependent with Medicare A&B
$213.09
My Cost

Dependent	Relationship	Covered
Bob Doe	Spouse	N

Dental
DeltaCare USA DHMO
Member Only
$30.93
My Cost

Dependent	Relationship	Covered
Bob Doe	Spouse	N

Vision Premier
VSP Premier Plan
Member Only
$10.50
My Cost

Dependent	Relationship	Covered
Bob Doe	Spouse	N

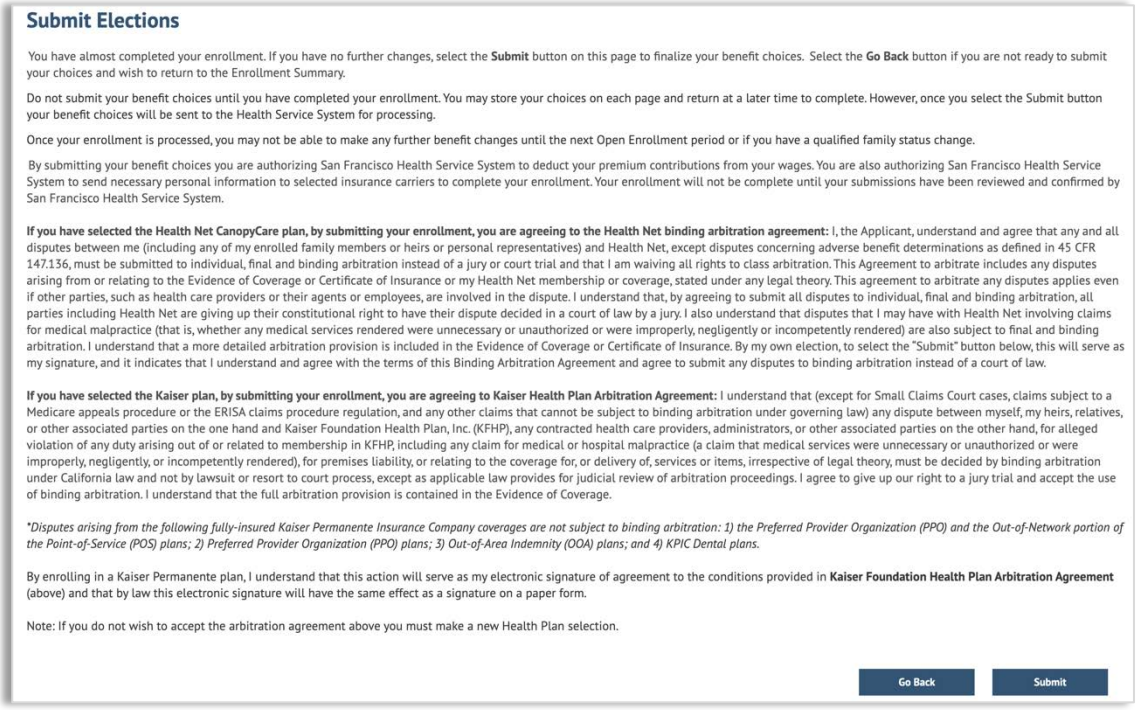
Cost Summary

Your Costs

Before Tax	$ 0.00
After Tax	$ 290.34
Total	**$ 290.34**

24. This is your opportunity to review your elections. To edit a section, click on the pencil. Click the **Continue** button. If you need to go back to a previous screen, use the breadcrumbs at the top of the page to navigate there.

Submit Elections



Submit Elections

You have almost completed your enrollment. If you have no further changes, select the **Submit** button on this page to finalize your benefit choices. Select the **Go Back** button if you are not ready to submit your choices and wish to return to the Enrollment Summary.

Do not submit your benefit choices until you have completed your enrollment. You may store your choices on each page and return at a later time to complete. However, once you select the Submit button your benefit choices will be sent to the Health Service System for processing.

Once your enrollment is processed, you may not be able to make any further benefit changes until the next Open Enrollment period or if you have a qualified family status change.

By submitting your benefit choices you are authorizing San Francisco Health Service System to deduct your premium contributions from your wages. You are also authorizing San Francisco Health Service System to send necessary personal information to selected insurance carriers to complete your enrollment. Your enrollment will not be complete until your submissions have been reviewed and confirmed by San Francisco Health Service System.

If you have selected the Health Net CanopyCare plan, by submitting your enrollment, you are agreeing to the Health Net binding arbitration agreement: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, must be submitted to individual, final and binding arbitration instead of a jury or court trial and that I am waiving all rights to class arbitration. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to individual, final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. By my own election, to select the "Submit" button below, this will serve as my signature, and it indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

If you have selected the Kaiser plan, by submitting your enrollment, you are agreeing to Kaiser Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

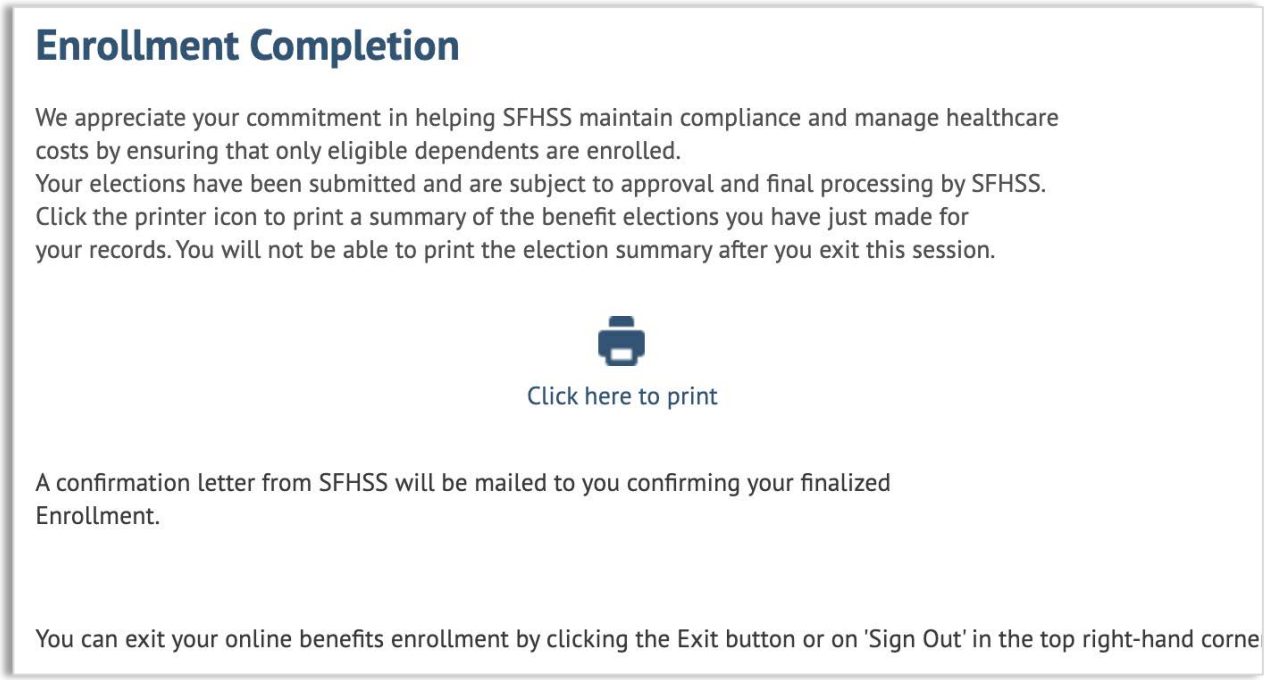
By enrolling in a Kaiser Permanente plan, I understand that this action will serve as my electronic signature of agreement to the conditions provided in **Kaiser Foundation Health Plan Arbitration Agreement** (above) and that by law this electronic signature will have the same effect as a signature on a paper form.

Note: If you do not wish to accept the arbitration agreement above you must make a new Health Plan selection.

Go Back | Submit

25. Click the **"Submit"** button. Your previous elections dropping your ineligible dependent from your health plan coverage have been submitted and will be reviewed and processed by SFHSS.

Enrollment Completion



26. Exit by clicking **Exit** or **Sign Out** in the top right-hand corner of the page.

Congratulations!

You have successfully removed your ineligible dependent from your health plan coverage. Your documentation will be reviewed by SFHSS and you will receive a letter in the mail regarding the status of your submission.

Questions?

Our phone hours are Monday, Tuesday, Wednesday, and Friday from 9am to 12pm and 1pm to 5pm and on Thursdays from 10am to 12pm and 1pm to 5pm at **(628) 652-4700**.