



**COUNTY OF SAN DIEGO
2017 HOURLY/TEMPORARY ENROLLMENT/CHANGE FORM**

Return completed form to the Employee Benefits Division – Mail Stop O7 or Fax 858-467-9708 or Email DHRBenefits.FGG@sdcounty.ca.gov

PERSONAL INFORMATION

Employee ID	Last Name	First Name	MI	Social Security #	Date of Birth	Date of Hire	Effective Date
Home Address				City	State	Zip Code	Phone
Enrollment Reason (Documentation Required): 2017 ACA Eligibility				Date of Enrollment Event:		Email Address:	

COVERAGE SELECTION – Please indicate the level of coverage in which you request to enroll or change.

MEDICAL PLAN

Employee Only Employee + One Dependent Employee + Two or More Dependents Kaiser Permanente – High Deductible Plan (Group 104301-0008)

Name (Last, First, MI)	Gender Relation	Date of Birth	REQUIRED Social Security #
Employee	Male/Female		
Spouse	Male/Female		
Domestic Partner	Male/Female		
Child	Son/Daughter		

If more dependents need to be added, please continue on separate page

Authorization/Acknowledgement

- Deduction Authorization:** I hereby authorize the County take any applicable before-tax and after-tax deductions from my salary and to pay such sums as are due to selected carriers. This authorization shall apply to any increase or decrease due to the County and is to continue in effect until coverage eligibility ends (1 year), or employment is terminated. Coverage and payment obligation are effective through the calendar month in which termination of coverage or employment occurs.
- Acknowledgement of Release of Enrollment/Change Information:** You authorize The County to transmit your enrollment and any dependent(s) demographic data to the plans in which you are enrolling or changing coverage.
- Dependent Coverage:** I hereby certify that the individuals listed on this enrollment form, if any, meet all the individual plans eligibility requirements.
- Arbitration Provisions:** *PLEASE READ CAREFULLY - Please sign Kaiser's Arbitration Agreement in which you and your dependent(s) are requesting a change or enrollment of coverage. SIGNATURE REQUIRED in the back of this form.*

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATION/ACKNOWLEDGEMENT.

Employee Signature _____ Date _____

Kaiser Foundation 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.

SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN

Employee Signature _____ Date _____