

**COUNTY OF SAN DIEGO  
2016 ENROLLMENT/CHANGE FORM**

Return completed form to the Employee Benefits Division – 5530 Overland Ave, Suit #210, San Diego, CA or Fax 858-467-9708 or Email [DHRBenefits.FGG@sdcounty.ca.gov](mailto:DHRBenefits.FGG@sdcounty.ca.gov)

**PARTICIPANT INFORMATION**

Participant ID (Employee ID)	Last Name	First Name	MI	Social Security #	Date of Birth	Effective Date <b>01/01/2016</b>
Home Address				City	State	Zip Code
Enrollment Reason (Documentation Required): <b>2016 COBRA OPEN ENROLLMENT</b>					Date of Enrollment Event:	
					Email Address:	

Coverage Selection – Please indicate the medical, dental and/or vision plan(s) in which you request to enroll or make coverage changes.

MEDICAL PLAN		DENTAL PLAN		VSP VISION PLAN
<input type="checkbox"/> Participant Only	<input type="checkbox"/> Anthem Blue Cross – PPO Prudent Buyer (Group- 2735360M002)	<input type="checkbox"/> Participant Only	<input type="checkbox"/> Delta Dental PPO (17214-09001)	<input type="checkbox"/> Participant Only
<input type="checkbox"/> Participant + One Dependent	<input type="checkbox"/> Anthem Blue Cross – Select HMO (Group- 275360H111)	<input type="checkbox"/> Participant + One Dependent	<input type="checkbox"/> DeltaCare USA DHMO (76990-09001)	<input type="checkbox"/> Participant + One Dependent
<input type="checkbox"/> Participant + Two or More Dependents	<input type="checkbox"/> Anthem Blue Cross - California Care / Full Access HMO (Group 275360H013)	<input type="checkbox"/> Participant + Two or More Dependents	<input type="checkbox"/> Waive Dental coverage	<input type="checkbox"/> Participant + Two or More Dependents
	<input type="checkbox"/> Anthem Blue Cross – High Deductible Plan (Group-275360M011)			<input type="checkbox"/> Waive Vision coverage
	<input type="checkbox"/> Kaiser Permanente – HMO (Group 104301-36)			
	<input type="checkbox"/> Kaiser Permanente – High Deductible Plan (Group 104301-7008)			
	<input type="checkbox"/> Waive Medical coverage (proof of other health coverage required)			

**SECTION BELOW MUST BE COMPLETED**

Name (Last, First, MI)	Gender Relation	Date of Birth	REQUIRED Social Security #	Medical Add / Drop	Dental Add / Drop	Vision Add / Drop	Anthem Blue Cross HMO Physician ID# <input type="checkbox"/> Select HMO <input type="checkbox"/> California Care / Full Access HMO	DeltaCare USA DHMO Facility ID# (Please visit <a href="http://deltadental.com">deltadental.com</a> for a list of providers)
Participant	Male/Fm						*	
Spouse	Male/Fm						*	
Domestic Partner	Male/Fm						*	
Child	Son/Dtr						*	
Child	Son/Dtr						*	
Child	Son/Dtr						*	

If more than two dependents, please continue on separate page

\*Providers must accept the HMO plan you selected.

**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 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 - For Kaiser Permanente and Anthem Blue Cross Plans only. Please read and sign the corresponding plan'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 \_\_\_\_\_

**Anthem Blue Cross Health Plan Arbitration Agreement**

***REQUIREMENT FOR BINDING ARBITRATION - The following provision does not apply to class actions:***

***IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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. Both parties to this contract, 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. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.***

**SIGNATURE REQUIRED FOR ANTHEM BLUE CROSS PLAN**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_