

**COUNTY OF SAN DIEGO
2016 BENEFITS 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

EMPLOYEE INFORMATION

Employee ID	Last Name	First Name	MI	Social Security #	Date of Birth	Date of Hire	Effective Date 01/01/2016
Home Address		City	State	Zip Code	Phone		
Enrollment Reason (Documentation Required): 2016 LEAVE OF ABSENCE OPEN ENROLLMENT				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"/> Employee Only	<input type="checkbox"/> Anthem Blue Cross – PPO Prudent Buyer (Group- 2735360M001)	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Delta Dental PPO - 17214	<input type="checkbox"/> Employee Only
<input type="checkbox"/> Employee + One Dependent	<input type="checkbox"/> Anthem Blue Cross – Select HMO (Group- 275360H110)	<input type="checkbox"/> Employee + One Dependent	<input type="checkbox"/> DeltaCare USA DHMO - 76990	<input type="checkbox"/> Employee + One Dependent
<input type="checkbox"/> Employee + Two or More Dependents	<input type="checkbox"/> Anthem Blue Cross - California Care / Full Access HMO (Group 275360H010)	<input type="checkbox"/> Employee + Two or More Dependents	<input type="checkbox"/> Waive Dental coverage	<input type="checkbox"/> Employee + 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 104301-02)			
	<input type="checkbox"/> Kaiser Permanente – High Deductible Plan (Group 104301-0008)			
	<input type="checkbox"/> Waive Medical coverage (proof of other health coverage required)			

The following documents are required as proof of relationship to add new dependents: For Spouse a Marriage Certificate; For Domestic Partner an Affidavit or Certificate of Domestic Partnership; For Dependents a Birth Certificate or other legal documentation.

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 deltadental.com for a list of providers)
Employee	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 _____