COUNTY OF SAN DIEGO
2021 HOURLY/TEMPORARY ENROLLMENT/CHANGE FORM

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

EMPLOYEE INFORMATION

Employee ID	Last Name	First Name	MI	Date of Eligibility	Effective Date
					01/01/2021
Home Address		City		State	Zip Code
Enrollment Reason **Temporary Employee Open Enrollment**	Email Address				Phone

COVERAGE SELECTION – Indicate the level of coverage in which you wish to enroll or make coverage changes.

MEDICAL PLAN	
❑ Employee Only	❑ Kaiser Permanente High Deductible Plan
❑ Employee + One Dependent	
❑ Employee + Two or More Dependents	

Name of Dependent (Last, First, MI)	Please circle Relationship type	Gender	Date of Birth	REQUIRED - Social Security Number *For a Newborn, please provide once obtained
	Spouse / Child / Domestic Partner	M / F		
	Spouse / Child / Domestic Partner	M / F		
	Spouse / Child / Domestic Partner	M / F		
	Spouse / Child / Domestic Partner	M / F		
	Spouse / Child / Domestic Partner	M / F		
	Spouse / Child / Domestic Partner	M / F		

Authorization/Acknowledgement

1. **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 carrier. 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.
2. **Acknowledgement of Release of Enrollment/Change Information**: You authorize The County to transmit your enrollment and any dependent(s) demographic data to the plan in which you are enrolling or changing coverage.
3. **Dependent Coverage:** I hereby certify that the individuals listed on this enrollment form, if any, meet all the individual plans eligibility requirements.
4. **Arbitration Provisions:** *PLEASE READ CAREFULLY – Please sign Kaiser Permanente Arbitration Agreement in which you and your dependent(s) are requesting a change or enrollment of coverage.* ***SIGNATURE REQUIRED on the back of this form.***

MY SIGNATURE 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_____