COUNTY OF SAN DIEGO

2025 BENEFITS 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: 0-7

EMPLOYEE INFORMATION

Employee ID	Last Name	First Name	Middle Initial

Home Address	City	State	Zip Code	Phone

Enrollment Reason	Date of Enrollment Event	Email Address:

Indicate the medical, dental and/or vision plan(s) you wish to enroll in or make coverage changes.
Contact carrier directly to select your **HMO** physician or dentist (no designation is necessary for PPO & SIMNSA plans). Medical – UnitedHealthcare -1-888-586-6365, DeltaCare USA DHMO 1-844-697-0579

MEDICAL PLAN		DENTAL PLAN		VSP VISION PLAN
☐ Employee Only	☐ UnitedHealthcare SignatureValue Performance HMO Network 1	☐ Employee Only	☐ Delta Dental PPO	☐ Employee Only
☐ Employee + One Dependent	☐ UnitedHealthcare SignatureValue CS VEBA Alliance HMO	☐ Employee + One Dependent	☐ DeltaCare DHMO	☐ Employee + One Dependent
☐ Employee + Two or More Dependents	☐ UnitedHealthcare/UMR Select Plus PPO	☐ Employee + Two or More Dependents	☐ Waive Dental coverage	☐ Employee + Two or More Dependents
	☐ UnitedHealthcare Harmony High Deductible Health Plan			☐ Waive Vision coverage
	☐ Kaiser Permanente HMO			
	☐ Kaiser Permanente High Deductible Health Plan			
	☐ SIMNSA Mexico HMO			
	☐ Waive Medical coverage (**waiver form required**)			

Supporting documentation is required as proof of relationship to add new dependents: Spouse - Marriage Certificate; Children – Birth Certificate or Court Documents; Domestic Partner - Affidavit or Certificate of Domestic Partnership. If you have additional dependents, please continue on separate page.

Name of Employee and Dependent(s) (Last, First, MI)	**Please select Relationship type** Employee / Spouse / Child / Domestic Partner	**Gender** M / F	**Date of Birth**	**REQUIRED - Social Security Number *For a Newborn, please provide once obtained**	**Medical** Add / Drop	**Dental** Add / Drop	**Vision** Add / Drop
	Employee						

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 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.
2. **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.
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 - For Kaiser Permanente, UnitedHealthcare and SIMNSA 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 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

My signature below indicates that I have carefully read the above "Binding Arbitration" language and agree to its terms.

Employee Signature _____Date_____

UnitedHealthcare Binding Arbitration Agreement

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates , shall be determined by submission to binding arbitration. Any such dispute will note be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review or arbitration proceedings. All parties to this agreement are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

SIGNATURE REQUIRED FOR UNITEDHEALTHCARE

My signature below indicates that I have carefully read the above "Binding Arbitration" language and agree to its terms.

Employee Signature _____ Date_____

SIMNSA Mexico HMO Binding Arbitration Agreement

Upon applying for membership of Sistemas Medicos Nacionales, S.A. for me and eligible members of my family, I accept the following:

1) **All services should be provided solely by SIMNSA providers, except in case of an Emergency as defined in the Plan document. 2) We shall not lend our member cards to others; doing so may result in immediate cancellation of coverage and penalties. 3) I understand that SIMNSA will obtain medical information for people listed on this application in order to administer the Plan. 4) I certify that the information on this application is valid and correct and that I understand the benefits and rules of this health Plan. 5) This Plan uses binding arbitration to settle all disputes arising under this Agreement. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered in California 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. For any disputes arising from services rendered in Mexico, Mexico 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. For more information, please refer to your Evidence of Coverage.**

SIGNATURE REQUIRED FOR SIMNSA Mexico HMO

My signature below indicates that I have carefully read the above "Binding Arbitration" language and agree to its terms.

Employee Signature _____ Date_____