# OPEN ENROLLMENT

***All changes effective January 1, 2018***

## SECTION 1. RETIREE INFORMATION

| Name ( Last, First, M.I.): | | | Social Security Number: | Date of Birth: |
|---|---|---|---|---|
| Home Address (Number, Street, Apt#): | | City: | State: | Zip Code: |
| Gender: ☐ Female ☐ Male | Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Domestic Partner ☐ Divorced | | Phone Number: | |
| Email Address: | | | | |

## SECTION 2: COVERAGE ELECTION

**MEDICAL**

**Under 65 Plans**
- ☐ Kaiser HMO
- ☐ Kaiser HDHP
- ☐ Blue Shield HMO
- ☐ Blue Shield PPO HDHP
- ☐ Blue Shield HMO TRIO

**Over 65 Plans**
- ☐ Kaiser Sr Advantage
- ☐ Blue Shield Medicare PPO
- ☐ United Healthcare

- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

**DENTAL** (Voluntary)
- ☐ Delta Dental HMO
- ☐ Cigna Dental PPO

- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

**VISION** (Voluntary)
- ☐ Vision Service Plan

- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

**RETIREE COMMENTS**

| Add / Remove | Relationship | Name (Last, First, M.I.) | Social Security Number | Date of Birth | Gender |
|---|---|---|---|---|---|
| | ☐ Spouse ☐ Domestic Partner | | | | ☐ M ☐ F |
| | Child 1 | | | | ☐ M ☐ F |
| | Child 2 | | | | ☐ M ☐ F |
| | Child 3 | | | | ☐ M ☐ F |

Have you included stepchildren as dependents? ☐ NO ☐YES - If "yes" indicate name(s): ___________________________

Do your stepchildren reside with you? ☐ NO ☐ YES Are they dependent upon you for support and maintenance? ☐ NO☐ YES

*Marriage Certificate, Domestic Partner Affidavit, Birth Certificate required.

# OPEN ENROLLMENT

## SECTION 3 ARBITRATION AGREEMENT AND SIGNATURE

**Kaiser Foundation Health Plan Arbitration Agreement:**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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 of Retiree ____________________________________ Date _____________

**Required for Kaiser Permanente HMO Plan**

**Blue Shield of California / Blue Shield Life Agreement:**

This Arbitration Agreement does not apply to Blue Shield of California/Blue Shield Life. All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life. Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law. For the purpose of administering your Blue Shield coverage. Blue Shield is permitted by state and federal law to obtain you and your organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site."

Signature of Retiree ____________________________________ Date _____________

**Required for Blue Shield Plans**

## SECTION 4: FINAL SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read, understand, and agree to the terms and conditions above.

Signature of Retiree: ________________________________________________ Date: _____________

**Enrollment Form Submission Instructions**

1) **Submit the form to the Benefits Office either by**
   a) **Fax at (650) 599-1573**
   b) **Email benefits@smcgov.org**
   c) **Mail to 455 County Center, Redwood City, CA 94063**
2) **Please print a copy of this form, sign and retain for your records.**

**Questions? Call Benefits at (650) 363-1919**

| **BENEFITS USE ONLY** | |
|---|---|
| Participant ID (CSM) | |
| Division Code Change ☐ No ☐ Yes: R ____ to R ____ | |
| EFT Needed ☐ No ☐ Yes (If yes, attached?) | |
| Sick Hour Change ☐ No ☐ Yes $_______ to $_______ | |
| Entered in BCC (Date/Initial) | Confirmation Sent (Date/Initial) |