2020 Medical Enrollment Form

Effective Date: January 1, 2020

Please complete and return to Human Resources no later than October 25, 2019

MEMBER ENROLLMENT – COMPLETE IN FULL			
Name (Last, First, MI):	Social Security #:	Birth Date (mm/dd/yy):	☐ Male ☐ Female
Home Street Address: (No P.O. Box) City State Zip		Home Phone:	Work Phone:
Mailing Address: (P.O. Box may be used) City State Zip		E-mail Address:	
Title/Department:	Date of Hire (mm/dd/yy):	Employee Status: ☐ Full Time ☐ Early Retiree ☐ Part Time	
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced			

TYPE OF ACTION
☑ Open Enrollment for 2020 Plan Year

MEDICAL - MEMBER ELECTION	
Kaiser Permanente HMO ☐ EE Only ☐ EE + 1 ☐ EE + Family Existing Patient: Yes / No	**Kaiser Permanente High Deductible Health Plan** ☐ EE Only ☐ EE + 1 ☐ EE + Family Existing Patient: Yes / No
Anthem Blue Cross PPO ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Anthem Blue Cross High Deductible Health Plan (HIGH 3K)** ☐ EE Only ☐ EE + 1 ☐ EE + Family
Anthem Blue Cross High Deductible Health Plan (LOW 5K) ☐ EE Only ☐ EE + 1 ☐ EE + Family	

DEPENDENT COVERAGE				
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child
☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City, State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child

ANTHEM AND KAISER ARBITRATION PLEASE READ CAREFULLY - SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.
DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.
NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
EFFECTIVE DATE: The effective date of coverage is subject to Anthem and/or Kaiser approval.
W–9 Certification Language
I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM AND/OR ANTHEM LIFE AND HEALTH INSURANCE COMPANY AND KAISER, 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, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENTPROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: ***It is understood that 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.*** **YOU AND ANTHEM AND/OR ANTHEM AND AND LIFE HEALTH INSURANCE COMPANY AND KAISER AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.**

Signature:	Date:

DECLINATION OF COVERAGE – SIGNATURE REQUIRED- Complete only if declining medical coverage

I understand that I am eligible for medical coverage through my employer. I waive the right to enroll in the medical plan as offered by my employer for the following persons (please check all that apply below):

☐ Self ☐ Spouse ☐ Child(ren)

Reason for waiver for self:

☐ I have other group coverage that I am enrolled in
☐ I am enrolled on the Medi-Cal government program program

Reason for waiver for dependents:

☐ My dependent(s) are enrolled in other group coverage
☐ My Dependent(s) are enrolled on the Medi-Cal government

I understand that by declining coverage, I or any family members waiving coverage will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other group coverage). Individual coverage is not qualified as other "group" coverage and the loss of individual coverage will not be a qualifying event to add coverage mid-year. I understand and agree by signing this document that I am declining coverage and if I fail to show proof of other group coverage that I will be added to the lowest cost plan automatically.

By signing below I am certifying that the above information is accurate and true.

Signature for declination of coverage:	Date:

Pre-Tax Contribution Agreement:

I authorize my employer to reduce my cash compensation as I have directed during the plan year following the date of this agreement. I fully understand and agree that:

- I may change my election(s) during the plan year ONLY if I experience a "qualifying and related change of status" as defined by the Plan and/or the Internal Revenue Code (IRC).
- The elections I have made are effective January 1, 2020. My employer is permitting me to make my contributions in equal installments each pay period for the sole purpose of making my participation in the Plan as convenient as possible.
- My elections are in addition to any other agreements I have with my Employer.
- This agreement is subject to all the terms and conditions of our Cafeteria Plan as amended from time to time and revokes any prior election (s) I may have completed.
- Prior to the start of each plan year, I will have the opportunity to change my elections for the following plan year. However, if I fail to change my elections I understand that I will continue the same coverages which I previously elected and authorize the deduction of the pre-tax contributions applicable for the following plan year except that failure to complete a new Cafeteria Plan Election Form shall preclude my participation in either the HCSA and/or DCSA for the year.

Employee Signature

I, the undersigned, certify that I have read and understand this Election form and I agree to abide by all the terms and conditions thereof.

Employee Signature_____

Date: _____/_____/_____

If you have any questions, please feel free to contact Human Resources at (209) 577-5402.