SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

Print Form

FOR ADMINISTRATIVE USE ONLY
Effective Date
Event Date
Reason
Plan No.

COBRA
MEDICAL PLAN ENROLLMENT/CHANGE FORM

CHOOSE ONE: ☐ NEW COBRA ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS ☐ CANCEL COVERAGE

SELECT PLAN

ACTIVE PLANS: ☐ BLUE SHIELD SIGNATURE HMO ☐ KAISER PERMANENTE ☐ BLUE SHIELD PPO ☐ BLUE SHIELD NEEDLES PPO ☐ BLUE SHIELD BRONZE PPO

DEPENDENT ONLY RETIREE PLANS: ☐ BLUE SHIELD SIGNATURE HMO *(NON-MEDICARE)* ☐ KAISER *(NON-MEDCARE)* ☐ OTHER: _____

OPTION: ☐ HIGH ☐ LOW

MAIN SUBSCRIBER INFORMATION

Check one ☐ MALE ☐ FEMALE | Check one ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED

Empl. No.	Social Security No.	Last Name	First Name	MI	Date of Birth	For name change, list former name here

Mailing Address ☐ Check here if new address	City	ST	ZIP	Phone ☐ HOME ☐ CELL ☐ WORK	Alternate Phone ☐ HOME ☐ CELL ☐ WORK

ENROLLEES - List ALL persons to be covered

Include yourself, if applicable. You must also attach proof of dependent eligibility if enrolling dependents for the first time.

Action	Name (Last Name, First Name)	Social Security No.	Sex	Date of Birth	Relationship	BLUE SHIELD SIGNATURE HMO ENROLLEES ONLY: ENTER BOTH DR. ID & GROUP ID NUMBERS	PREVIOUSLY VISITED?
☐ Add ☐ Remove			☐ M ☐ F		Self	DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N
☐ Add ☐ Remove			☐ M ☐ F			DR. ID # GROUP ID #	☐ Y ☐ N

OTHER MEDICAL COVERAGE

Are you or any other enrollee covered by other group medical insurance? ☐ No ☐ Yes - Please complete the following:

Enrollee's Name	Date of Birth	Insurance Company	Policy No.

MEDICARE COVERAGE - List all enrollees that are covered by Medicare Parts A & B.

Enrollee's Name	Date of Birth	Medicare ID No.

ENROLLED DISABLED DEPENDENTS - List the names of any disabled dependents you are enrolling below:

Last Name, First Name, MI	Last Name, First Name, MI

CONTINUED ON NEXT PAGE

DISTRIBUTION: HR - EBSD (0440)

KAISER PERMANENTE MEMBERS ONLY

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 **Date**

BLUE SHIELD MEMBERS ONLY

Authorization

I agree: 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 committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of coverage, my coverage may be cancelled or rescinded. I further authorize my employer to deduct from my earning contribution (if any) required towards the cost of this plan.

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.

Disclosure of Personal Health Information

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 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 your and your dependents' health information from a healthcare provider, insurer, insurance support 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 website.

QUALIFIED CHANGE IN STATUS

I understand that I may elect to add or delete eligible dependents to my medical plan if a "Qualifying Change in Status Event" occurs. Qualifying events are:

- Marriage, domestic partnership, divorce, dissolution of domestic partnership or legal separation of the member
- Birth or adoption of a child by the member
- Termination or commencement of a spouse's or domestic partner's employment
- Over age dependent
- Unpaid leave of absence taken by the member's spouse or domestic partner
- A significant change in the medical coverage of the member or dependents attributable to the spouse's or domestic partner's employment, such as offering insurance for the first time or a significant increase or decrease in premium cost
- Medicare entitlement

To add or delete dependents, I understand that I must submit a new Medical Plan Enrollment/Change Form within sixty (60) days of a Qualifying Change in Status Event. If I do not submit a Medical Plan Enrollment/Change Form within sixty (60) days, my request may be denied. All requests must be consistent with the stated qualifying event.

CONTINUED ON NEXT PAGE

AGREEMENT - THIS SECTION MUST BE COMPLETED BY ALL SUBSCRIBERS

I certify that I have read and understand my and/or my dependents' COBRA Rights and Obligations enclosed in my COBRA Election Notice. I hereby elect to enroll in (or elect an authorized change to) the group health and welfare plan maintained by the County of San Bernardino designated at the beginning of this form. I have also designated in the ENROLLEES section my eligible dependents who are to be enrolled into the medical plan. I agree to be responsible for the full applicable premium payment for the coverage selected, which will include a 2% administration charge. I understand that failure to pay premiums timely will result in the termination of coverage and that my and my dependents' COBRA rights will be forfeited.

I agree for myself and my dependents, effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the Group Agreement, as it may be amended,
- To obtain all medical services from providers associated with the medical plan, unless the plan specifically provides otherwise,
- To authorize providers who have rendered services to me and my dependents to make medical information and records regarding those services to the medical plan and their providers, who in turn, may share such records among themselves. This information may also be released to appropriate government agencies,
- To complete and submit consents, releases, assignments and other documents related to protecting the medical plan's rights under the Group Agreement. This includes coordinating benefits with other group medical plans, insurance policies or Medicare. I also agree to pay the costs incurred by the medical plan out of any awards, settlements or payments made to me in connection with personal injuries sustained by me or my dependents, and

I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to my health insurance carrier for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement and disease or care management programs. The health insurance carriers' Notice of Privacy Practices can be obtained at their respective websites or by calling the health insurance carriers' member services.

I certify that, to the best of my knowledge, all information furnished by me here is true and correct. I certify that the names of the persons listed in the Medicare Coverage section are enrolled in Parts A & B of Medicare.

I also certify that I accept the above terms of the plan to which I subscribe.

IF APPLICABLE: I authorize the County of San Bernardino to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment (including any future premium increases or decreases).

Subscriber's Signature _____ *Date* _____

To authorize that your monthly COBRA payment be deducted from the monthly retirement benefit payment of your spouse, parent or state-registered domestic partner AND he or she is not enrolled in your COBRA plan, the section below must be completed by the parent, domestic partner, or spouse (the "Payee").

I, _____ (payee), authorize the San Bernardino County Employees' Retirement Association (SBCERA) to deduct from my monthly retirement benefit payment in the amount required to cover the COBRA monthly payment for my dependent, _____ (COBRA subscriber), including any future increases or decreases.

Payee's Signature _____ *Date* _____

For identification purposes, please provide one of the following:

Payee Employee No. **OR** *Last 4 digits of SSN:* _____

County of San Bernardino
Human Resources Department
Employee Benefits and Services Division - COBRA
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
Phone: (909) 387-5552