



ANDREW LAMBERTO
Director of Human Resources

COUNTY OF SAN BERNARDINO

Human Resources Department
Employee Benefits and Services Division
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787
FAX: (909) 387-5566



BOARD OF SUPERVISORS

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Gary C. Ovitt.....Fourth District
Josie Gonzales.....Fifth District

October 18, 2012

John Doe
123 Any Street
Anytown, CA 12345

Dear John Doe:

Subject: Health Net Retiree Medicare Plan

The Employee Benefits and Services Division (EBS) of the County of San Bernardino is committed to helping you make informed health care decisions. Our records indicate that you and/or your dependent are currently enrolled in a Health Net Medicare plan. This letter contains important information about your enrollment options for the 2013 plan year.

Effective January 1, 2013, Blue Shield of California is replacing Health Net as a medical carrier for the County of San Bernardino. Coverage under Health Net will no longer be offered through the County. The Blue Shield Medicare plans offer comparable coverage to the current Health Net Medicare plans.

Important Note: If you or your dependent(s) wish to remain enrolled in a Medicare plan sponsored by the County, please complete the enclosed enrollment forms and return them to EBS at the address listed on the forms no later than November 30, 2012. EBS must receive forms from you if you wish to remain enrolled in a County-sponsored Medicare plan. If we do not receive enrollment forms from you by November 30, 2012, enrollment in County-sponsored medical coverage will end at midnight on December 31, 2012. If you choose not to exercise this option and take no other action, please be aware that you and/or your dependents will only have traditional Medicare Coverage starting January 1, 2013.

Additionally, if you are enrolled in a Health Net Medicare plan and have dependent(s) who are enrolled in a Health Net non-Medicare plan and you do not submit enrollment forms during Open Enrollment, coverage for your dependent(s) through the County will also end at midnight on December 31, 2012.

The 2013 Open Enrollment period is November 1 through November 30, 2012. A copy of the 2013 Retiree Benefits Guide will be mailed to your home address in mid-October 2012. The guide may also be viewed online at www.sbcounty.gov/hr/Benefits_Retire.aspx. The guide contains information about different enrollment options that may be available to you based on your residence and Medicare enrollment. Should you have any questions, please feel free to contact the following for more information:

- Blue Shield Medicare Customer Service at 800-776-4466
- Kaiser Permanente Medicare Customer Service at 877-882-2687
- EBS at 909-387-5787 or toll free at 888-743-1474

Sincerely,

Jeanne Groen, Benefits Chief
Employee Benefits and Services Division

Enclosures



San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

RETIREE MEDICAL PLAN ENROLLMENT/CHANGE FORM

For Office Use Only			
Effective Date	Month	Day	Year
Group ID #			
Emp ID #			

A. New Retiree Open Enrollment Change in Status

B. I choose the following Medical Plan: <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> Blue Shield Signature HMO <input type="checkbox"/> Kaiser Medicare Advantage* <input type="checkbox"/> Blue Shield PPO <input type="checkbox"/> Kaiser Permanente Medicare COB <input type="checkbox"/> Blue Shield PPO COB <input type="checkbox"/> Blue Shield 65 Plus (HMO)*	Option: <input type="checkbox"/> High Option <input type="checkbox"/> Low Option For PPO Only: <input type="checkbox"/> California <input type="checkbox"/> Out of State
*Medicare integrated plan. Please complete both the County and the Medicare enrollment form. Previous Medical Plan:	

C. Retiree or Eligible Surviving Dependent Information					
Social Security Number	Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Month	Day	Year
		Check One			
		<input type="checkbox"/> Married		<input type="checkbox"/> Widowed	
		<input type="checkbox"/> Single		<input type="checkbox"/> Divorced	
		<input type="checkbox"/> Domestic Partner			
Last Name		First Name		MI	For Name Change, List Former Name Here
Mailing Address <input type="checkbox"/> Check Here If New Address				Home Phone ()	
				Alternate Phone ()	
City		State	Zip Code	Blue Shield Signature HMO and 65 Plus HMO Primary Care Physician ID No./Group ID No.	
Residential Address (if different from mailing address)				Previously Visited? <input type="checkbox"/> Yes <input type="checkbox"/> No	

D. NEW ENROLLMENT ONLY					Blue Shield HMO & 65 Plus HMO Enrollees Only	
IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED						
Last Name	First Name	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
Spouse/Domestic Partner:					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual open enrollment period.

E. ENROLLMENT CHANGES ONLY					Blue Shield HMO & 65 Plus HMO Enrollees Only	
IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED						
Last Name	First Name	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
<input type="checkbox"/> Add <input type="checkbox"/> Remove Spouse/Domestic Partner:					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove Children:					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove					Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

F. IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE OR DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH	Month	Day	Year	<input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Dissolution <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death
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G. OTHER MEDICAL COVERAGE	H. MEDICARE COVERAGE
Are you or any other member of your family covered by other group medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company _____ Policy No. _____ Spouse's Employer _____ Phone Number _____	List all family members enrolled in both Parts A & B of Medicare: Name (First, Middle, Last) _____ ID No. _____ Date of Birth (Month, Day, Year) ____/____/____ Name (First, Middle, Last) _____ ID No. _____ Date of Birth (Month, Day, Year) ____/____/____

Please read the following disclosures and sign your Agreement on the last page of this form.

<p>I. KAISER PERMANENTE MEMBERS ONLY (THIS SECTION APPLIES IF ENROLLING IN THE KAISER PERMANENTE PLAN)</p>
<p>Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, 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 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 <i>Evidence of Coverage</i>.</p>
<p>J. BLUE SHIELD OF CALIFORNIA MEMBERS ONLY (THIS SECTION APPLIES IF ENROLLING IN THE BLUE SHIELD PLAN)</p>
<p>Authorization The following authorization section is to be signed by all retirees applying for coverage with Blue Shield of California. 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 that my coverage may be cancelled. I understand that coverage does not become effective until this and the County's application have been approved by Blue Shield of California. Disclosure of Personal Health Information Blue Shield of California (Blue Shield) understands 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 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 at 1-800-642-6155 or by accessing Blue Shield's website at www.blueshieldca.com.</p>
<p>K. DEPENDENT AFFIDAVIT</p>
<p>I understand and agree to each of the following:</p> <ul style="list-style-type: none"> • My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. <i>A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.</i> • If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistencies discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken. • The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans. • It is my responsibility to: <ul style="list-style-type: none"> • notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage • provide supporting documentation upon request of HR-EBSD • I am responsible for any applicable cost incurred for obtaining supporting documentation. • The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively. • If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf. • Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s). <p>By signing below, I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).</p>
<p>L. DISABLED DEPENDENTS</p>
<p>Please list the names of any disabled dependents you are enrolling in the space below:</p> <p>_____</p> <p>_____</p>

M.	QUALIFIED CHANGE IN STATUS EVENT
<p>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:</p> <ul style="list-style-type: none"> • Marriage, domestic partnership, divorce or dissolution of domestic partnership of the member • Birth or adoption of a child by the member • Death • Termination or commencement of a spouse's or domestic partner's employment • Over age dependent • 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 <p>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.</p>	
N.	SELECTION OF A LOW OPTION HEALTH PLAN
<p>I hereby acknowledge that I understand the following in connection with the County of San Bernardino's Low Option Health Plan (Low Option) through either Kaiser Permanente or Blue Shield of California or any subsequent health plan provider(s):</p> <ul style="list-style-type: none"> • My decision to participate in the Low Option Plan is completely voluntary and is made with full understanding of the risks and potential additional expenses including applicable deductibles and increases in co-payments or co-insurances. • I understand that by selecting the Low Option Plan my out-of-pocket expenses for medical care will increase. • The County and the health plans have provided me with access to education and communications on the Low Option Plan. <p>I hereby release the County of San Bernardino and the Board of Supervisors from any fiduciary (or other) liability and responsibility for any losses incurred or other adverse consequences experienced in connection with my Low Option decisions.</p>	
O.	AGREEMENT
<p>I hereby elect the medical plan as designated on this enrollment form. I have also listed eligible dependents added to the medical plan, or to be deleted from the plan.</p> <p>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).</p> <p>I agree for myself and my dependents, effective immediately and for as long as necessary to process claims:</p> <ul style="list-style-type: none"> • 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 available 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 cost 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 <p>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 carrier's Notice of Privacy Practices is included in their evidence of coverage or certificate of insurance for coverage. A copy of this notice can be obtained by calling the health insurance carrier's member services.</p> <p>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 Section H are enrolled in Parts A & B of Medicare.</p> <p>I also certify that I accept the above terms of the plan to which I subscribe.</p> <p>Subscriber's Signature _____ Date _____</p>	

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440



San Bernardino County
 Employee Benefits and Services Division (EBSD)
 157 West Fifth Street, First Floor
 San Bernardino, CA 92415-0440
 (909) 387-5787 Fax (909) 387-5566

RETIREE DENTAL PLAN ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #			
Employee ID #			

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B I ELECT THIS DENTAL PLAN: Cigna Dental PPO Cigna Dental Care HMO

C RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVING DEPENDENT INFORMATION

1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth Month Day Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address <input type="checkbox"/>		10. Home Phone: ()	
11. City		Alternate Phone: ()	
12. State	13. Zip Code	14. Cigna Dental Care HMO members must provide the following: Provider Name _____ Provider No. _____	

D NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS DENTAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

Last Name	First Name	Social Security No.	Date of Birth	Relationship	Provider Name/No.
Spouse/Domestic Partner:					
Children:					

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next Open Enrollment Period.

E ENROLLMENT CHANGES ONLY IF YOU ARE ADDING OR REMOVING DEPENDENT(S) BUT NOT CHANGING PLANS, COMPLETE THIS SECTION

Name of family member(s) to be added or deleted:	Social Security No.	Date of Birth	Relationship	Provider Name/No.
<input type="checkbox"/> Add Spouse/Domestic Partner:				
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add Children:				
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add				
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add				
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add				
<input type="checkbox"/> Remove				

F IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH

	MONTH	DAY	YEAR	<input type="checkbox"/> DOMESTIC PARTNERSHIP	<input type="checkbox"/> DISSOLUTION
	/	/		<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> DIVORCE
				<input type="checkbox"/> DEATH	

G OTHER DENTAL COVERAGE

Are you or any other member of your family covered by other group dental insurance? Yes No

Insurance company _____ Spouse's/Domestic Partner's employer _____

Policy no. _____ Phone number () _____

H Retiree Authorization:

I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize disclosure to a hospital or dental care plan, employer, self-insurer or insurer any such dental information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

Dependent Affidavit:

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistencies discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken.

- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
- notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage
- provide supporting documentation upon request of HR-EBSD
- I am responsible for any applicable cost incurred for obtaining supporting documentation.
- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
- Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below:

- ✓ I elect to enroll in (or make the above changes to) the dental plan as shown above and authorize deduction to be made from my monthly retirement benefit payment to cover my share of the cost of enrollment as it is now or as it may be in the future. **Retirees who enroll in the Dental program are required to participate for a minimum of 24 consecutive months.**
- ✓ I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

Retiree's Signature

Date

Rev. 09/14/12

RETURN FORM TO:

**San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440**

Kaiser Permanente Senior Advantage (HMO)

**GROUP ELECTION
REQUEST FORM**

KAISER PERMANENTE®

Northern California or Southern California Region

IMPORTANT INFO – Read all pages before signing this form

Completing and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815**, toll free (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B, however some employer groups require both Parts A and B. You must live inside our Senior Advantage service area to enroll. Please check your enrollment materials to be sure you qualify for enrollment.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

- Fill out the form completely and mail the signed form to:
 - San Bernardino County
 - Employee Benefits and Services Division (EBSD)
 - 157 West Fifth Street, First Floor
 - San Bernardino, CA 92415-0440
- Keep the bottom copy for your own records. If required, also send a copy to your employer group or union/trust fund.
- We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
- We'll notify Medicare that you've applied to join Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

**Employer Group Use Only
Optional Group Stamp Area:**

Employer Group # _____ Employer Receipt Date _____
 Authorized Rep _____

Please contact Kaiser Permanente if you need information in another language or format (Braille).

To enroll in Kaiser Permanente Senior Advantage, please provide the following information:

Employer or Union Name			Group #
Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date (__/__/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number ()	Alternate Phone Number ()
Are you a current or former member of any Kaiser Permanente health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Current <input type="checkbox"/> Former			
Kaiser Permanente Medical/Health Record Number _____			
Permanent Residence Street Address (P.O. Box is not allowed)			
City	County	State	ZIP Code
Mailing Address (only if different from your Permanent Residence Address)			
Street Address	City	State	ZIP Code
E-mail Address			

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card
- OR -
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
HOSPITAL (Part A)			_____	
MEDICAL (Part B)			_____	

KAISER PERMANENTE SENIOR ADVANTAGE ELECTION FORM

FORMS

Last Name _____ First Name _____

Please read and answer these important questions:

1. Are you the retiree? Yes No
If yes, retirement date (month/date/year) _____
If no, name of retiree _____
2. Are you covering a spouse or dependents under this employer or union plan? Yes No
If yes, name of spouse _____
Name of dependents _____
3. Do you or your spouse work? Yes No
4. Do you have End-Stage Renal Disease (ESRD)? Yes No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
Will you have other prescription drug coverage in addition to Kaiser Permanente? Yes No
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage.
Name of other coverage _____ ID # for this coverage _____
6. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If "yes", please provide the following information:
Name of institution _____
Address & phone number of institution (number and street) _____
7. Requested effective date (subject to CMS approval) ____/____/____

Please check one of the boxes below if you would prefer for us to send you information in a language other than English or in another format:

Spanish

This information is available for free in other languages. Please contact Member Services at **1-800-443-0815** (TTY **1-800-777-1370**) for additional information (seven days a week, 8 a.m. to 8 p.m.).

Se puede obtener esta información gratis en otros idiomas. Si desea información adicional, por favor llame a Servicios a los Miembros al **1-800-443-0815** (TTY **1-800-777-1370**) (los siete días de la semana, de 8 a.m. a 8 p.m.).

Last Name _____ First Name _____

Please complete the information below.

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID# _____ Subgroup _____

Requested effective date (subject to CMS approval) _____

Please Read and Sign Below

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 coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), 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*.

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Senior Advantage Evidence of Coverage* document from Kaiser Permanente when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Last Name _____ First Name _____

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Kaiser Permanente and other services contained in my Senior Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature _____ **Today's Date** _____

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number (_____) _____ - _____

Relationship to Enrollee _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment) _____

Plan ID # _____ Effective Date of Coverage _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____

2012 NCAL or SCAL Group Plan Election Form

SKU 60078689 (10/2011)

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440

2013 Enrollment Request Form Blue Shield 65 Plus (HMO) Employer Group/Union Health Plan

This form is for Medicare-eligible retirees who want to enroll in the Blue Shield 65 PlusSM HMO, a group Medicare Advantage-Prescription Drug Plan.

To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.

Employer group or union name _____ Group or union No. _____
(leave blank if not provided by your employer group or union)

Last name		First name		Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (__ __ / __ __ / __ __ __ __) (MM / DD / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()		Alternate phone number ()	

Permanent residence (no P.O. boxes)

Street address _____

City	State	ZIP code
------	-------	----------

Mailing address (only if different from your permanent residence address)

Street address _____

City	State	ZIP code
Emergency contact (optional)	Relationship to you (optional)	Phone number (optional) ()

E-mail address (optional) _____

- I am willing to receive required plan materials via e-mail (i.e., enrollment notifications, the Annual Notice of Change and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card.
- OR -
- Attach a copy of your Medicare card, or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE			HEALTH INSURANCE	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To		Effective Date		
HOSPITAL (Part A)		_____		
MEDICAL (Part B)		_____		

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blueshieldca.com

Please read and answer these important questions

1. Are you the retiree? Yes No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

2. Are you covering a spouse or dependent(s) under this employer group or union plan?
 Yes No

If yes, name of spouse* _____

Name of dependent(s) _____

* Please ensure both you, your spouse, and dependent(s) each complete and return an enrollment form.

3. Do you or your spouse work? Yes No

4. Are you enrolled in your State Medicaid (Medi-Cal) program? Yes No

If yes, please provide your Medicaid (Medi-Cal) number _____

5. Do you have end-stage renal disease (ESRD)? Yes No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

6. Some individuals may have other coverage, including other private insurance, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus? Yes No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage.

Prescription drug coverage

Name of other coverage _____

ID No. for this coverage _____ Group No. _____

Medical coverage

Name of other coverage _____

ID No. for this coverage _____ Group No. _____

7. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If yes, please provide the following information:

Name of institution _____

Address and phone number of institution (number and street) _____

Please choose a primary care physician (PCP) and affiliated medical group

Your physician choice name

Physician ID No.

Name of medical group affiliated with your physician choice

Are you already a patient of this physician? Yes No

Please contact Blue Shield 65 Plus at **(800) 776-4466** [TTY **(800) 794-1099**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language.

**Please read and sign below****By completing this enrollment application, I agree to the following:**

Blue Shield 65 Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (for example, during your group's open enrollment period, or during the Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Blue Shield 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue Shield 65 Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Shield 65 Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus coverage begins, I must get all of my health care from Blue Shield 65 Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus and other services contained in my Blue Shield 65 Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS WILL PAY FOR THE SERVICES.**

Release of information

By joining this Medicare health plan, I acknowledge that Blue Shield 65 Plus will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Blue Shield 65 Plus will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Enrollee signature _____

Today's date _____

If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information

Name _____	Address _____
Phone number () _____	Relationship to enrollee _____

RETURN FORM TO:

**San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440**

Office use only:

Name/signature of staff member/agent/broker (if assisted enrollment)

Plan ID No. _____

Effective date of coverage _____

ICEP/IEP _____ AEP _____

SEP (type) _____ Not eligible _____

2013 Enrollment Request Form Blue Shield of California Medicare Rx Plan (PDP) Employer Group/Union Prescription Drug Benefit Plan

This form is for Medicare-eligible retirees who want to enroll in the Blue Shield of California Medicare Rx Plan (PDP), a Group Prescription Drug Benefit plan.

To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.

Employer group or union name _____ Group or union No. _____
(leave blank if not provided by your employer group or union)

Last name		First name		Middle initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (____/____/____) (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home phone number ()		Alternate phone number ()	

Permanent residence (no P.O. boxes)

Street address _____

City _____ State _____ ZIP code _____

Mailing address (only if different from your permanent residence address)

Street address _____

City _____ State _____ ZIP code _____

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional) ()
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E-mail address (optional) _____

- I am willing to receive required plan materials via e-mail (i.e., enrollment notifications the Annual Notice of Change and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card.
- OR -
- Attach a copy of your Medicare card, or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

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MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex _____

_____ - _____ - _____

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

Please read and answer these important questions

1. Are you the retiree? Yes No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

2. Are you covering a spouse or dependent(s) under this employer group or union plan?
 Yes No

If yes, name of spouse* _____

Name of dependent(s) _____

* Please ensure both you, your spouse, and dependent(s) each complete and return an enrollment form.

3. Do you or your spouse work? Yes No

4. Are you enrolled in your State Medicaid (Medi-Cal) program? Yes No

If yes, please provide your Medicaid (Medi-Cal) number _____

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the Blue Shield of California Medicare Rx Plan? Yes No

If yes, please list your other coverage and your identification (ID) number(s) for this coverage

Name of other coverage _____

ID No. for this coverage _____

Group No. for this coverage _____

6. Are you a resident in a long-term care facility, such as a nursing home? Yes No

If yes, please provide the following information

Name of institution _____

Address and phone number of institution (number and street) _____

Phone number of institution () _____

Please contact Blue Shield of California Medicare Rx Plan at **(888) 239-6469** [TTY **(888) 239-6482**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language.



Please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining the Blue Shield of California Medicare Rx Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

Please read and sign below

By completing this enrollment application, I agree to the following:

Blue Shield of California Medicare Rx Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Blue Shield of California Medicare Rx Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at any time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Shield of California Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available (for example, during my group's open enrollment period or the Annual Enrollment Period, October 15 – December 7), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency, when I cannot reasonably use Blue Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Shield of California Medicare Rx Plan when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the State Medicaid program and the Medicare Savings Program.

Release of information

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment, and 2) documentation of this authority is available upon request by Medicare.

Enrollee signature

Today's date

If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information

Name	Address
Phone number ()	Relationship to enrollee

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440

Medicare Prescription Drug Plan Use Only:

Plan ID No. _____ NIPR# _____

Effective Date of Coverage _____ IEP _____ AEP _____ SEP (type) _____

Plan Representative/Agent/Broker Signature _____