



San Bernardino County
Employee Benefits and Services Division (EBS)
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 #
Employee ID #

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B I CHOOSE THIS MEDICAL PLAN:
Kaiser Permanente Health Net Elect Open Access HMO
Kaiser Medicare Advantage\* Health Net PPO
Kaiser Permanente Medicare COB Health Net PPO Medicare COB
Health Net Seniority Plus\*
\*Medicare integrated plan. Please complete both the County and the health plan enrollment form.
PREVIOUS MEDICAL PLAN:

Option:
High Option
Low Option
For PPO only
California
Out-of-State

C RETIREE INFORMATION

1. Social Security No. 2. Check One: Male Female 3. Date Of Birth Month Day Year 4. Check One: Married Widowed Single Divorced 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
10. Home Phone ( ) Alternate Phone ( )
11. City 12. State 13. Zip Code 14. Health Net HMO and Seniority Plus Primary Care Physician ID No./Group ID No. Previously Visited? Yes No
15. Residential Address (if different from mailing address)

D NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Social Security #, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited? (Yes/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 IF YOU ARE ADDING OR DELETING DEPENDENT(S) (BUT NOT CHANGING PLANS), COMPLETE THIS SECTION Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Social Security #, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited? (Yes/No)

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

G OTHER MEDICAL COVERAGE
Are you or any other member of your family covered by other group medical insurance?
Insurance company
Policy no.
Spouse's employer
Phone number

H MEDICARE COVERAGE
List all family members enrolled in both Parts A & B of Medicare:
Name (first, middle, last)
ID no. Date of birth (month, day, year)

PLEASE READ THE FOLLOWING SECTIONS I THROUGH O AND SIGN WHERE INDICATED

MEDICAL PLAN ENROLLMENT/CHANGE FORM

FORMS

**I**

**KAISER PERMANENTE MEMBERS ONLY**  
(THIS SECTION APPLIES IF ENROLLING IN THE KAISER PERMANENTE PLAN)

I understand that (except for Small Claims Courts cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs 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, 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 my 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.

**J**

**HEALTH NET MEMBERS ONLY**  
(THIS SECTION APPLIES IF ENROLLING IN THE HEALTH NET PLAN)

**ACCEPTANCE OF COVERAGE**

**THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the web site at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center.

**NOTICE:** For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the purpose of payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**California Law prohibits an HIV test from being used by health insurance companies as a condition of obtaining health insurance coverage.**

**ACKNOWLEDGEMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

**BINDING ARBITRATION AGREEMENT: Subject to their terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.),** I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DP Entities and/or the Fidelity Entities, regarding construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or DBP Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

**K**

**HEALTH NET MEMBERS ONLY**  
(THIS SECTION APPLIES IF ENROLLING IN THE HEALTH NET PLAN)

Declining Medical coverage for:

Self    Spouse    Domestic Partner    Dependent(s)

The available coverage has been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s)

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**L**

**HEALTH NET MEMBERS ONLY**  
(THIS SECTION APPLIES IF ENROLLING IN THE HEALTH NET PLAN)

Please list the names of any disabled dependents you are enrolling in the space below:

\_\_\_\_\_

\_\_\_\_\_

**M** QUALIFIED CHANGE IN STATUS EVENT

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 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

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.

**N** 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 Health Net of California or any subsequent health plan provider(s):

- 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.

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.

**O** AGREEMENT

I hereby elect the medical plan designated in Section B. In Section D/E, I have also listed eligible dependents added to the medical plan, or to be deleted from the plan.

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).

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 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

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.

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.

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

Subscriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

**RETURN FORM TO:**

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