157 West Fifth Street, San Bernardino, CA 92415-0440 | Phone: 909.387.5787 • Fax: 909.387.5566
www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

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. CHOOSE A MEDICAL PLAN AND A HIGH OR LOW OPTION

☐ Kaiser Permanente Traditional HMO Plan
☐ Kaiser Medicare Advantage *
☐ Kaiser Permanente w/Medicare Unassigned
☐ Blue Shield Signature HMO
☐ Blue Shield PPO
☐ Blue Shield PPO COB
☐ Blue Shield 65 Plus (HMO) *

Medicare integrated plan. *Please complete both the County and the Medicare enrollment form.

Previous Medical Plan:

Option:
☐ High Option
☐ Low Option

For PPO Only:
☐ California
☐ Out of State

C. RETIREE OR ELIGIBLE SURVIVING DEPENDENT INFORMATION

Social Security Number	Check One: ☐ Male ☐ Female	Date of Birth Month / Day / Year	Check One ☐ Married ☐ Single ☐ Domestic Partner ☐ Widowed ☐ Divorced

Last Name	First Name	MI	For Name Change, List Former Name Here

Mailing Address ☐ 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.	Previously Visited? ☐ Yes ☐ No
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** — **Blue Shield HMO & 65 Plus HMO Enrollees Only**

Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
Spouse/Domestic Partner:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
Children:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ 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 ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED** — **Blue Shield HMO & 65 Plus HMO Enrollees Only**

Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
☐ Add ☐ Remove	**Spouse/Domestic Partner:**	☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove	**Children:**	☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ 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

☐ Domestic Partnership ☐ Dissolution
☐ Marriage ☐ Divorce ☐ Death

PLEASE READ THE FOLLOWING DISCLOSURES AND SIGN YOUR AGREEMENT ON THE LAST PAGE OF THIS FORM

G. OTHER MEDICAL COVERAGE	H. MEDICARE COVERAGE
Are you or any other member of your family covered by other group medical insurance? ☐ Yes ☐ 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) _____/_____/_____

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

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, or any 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.

J. BLUE SHIELD OF CALIFORNIA MEMBERS ONLY
(THIS SECTION APPLIES IF ENROLLING IN THE BLUE SHIELD PLAN)

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.

K. 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 inconsistences 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 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).

DISABLED DEPENDENTS

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. SELECTION OF A LOW OPTION HEALTH PLAN

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):

- 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 as designated on this enrollment form. 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_____