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HR
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COUNTY OF SONOMA EXTRA HELP EMPLOYEE MEDICAL PLAN ENROLLMENT/CHANGE FORM

☐ Annual Enrollment ☐ New Hire/Newly Eligible Date _____ ☐ Enter Event Date _____

EMPLOYEE INFORMATION			**FOR COUNTY USE ONLY: Effective Date** Medical _____ **Date entered in eP:** _____ **HR Technician Initials:** _____		
Last Name	First Name		Middle Name	FTE	Employee ID
Social Security Number	Date of Birth	Check One ☐ Male ☐ Female	Marital Status ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed		Bargaining Unit
Residential Address (Required) ☐ Check Box if new address			City	State	Zip Code
Mailing Address ☐ Check Box if Same as Residential			City	State	Zip Code
Personal Email Address	Work Phone		Personal Phone		Other Phone
Is your spouse/domestic partner/dependent an employee or retired employee of the County of Sonoma? ☐ Yes ☐ No			☐ Employee ☐ Retiree	If yes, list name(s):	

REASON FOR ENROLLMENT/CHANGE *Check ALL Boxes that apply*	**ADD/DROP/WAIVE DEPENDENT COVERAGE** *Check ALL Boxes that apply*
☐ Annual Enrollment ☐ Newly Eligible Extra Help Employee ☐ Other _____ ☐ Loss of Other Group Coverage ☐ Reenrollment/Reinstatement ☐ Cancel Extra Help Employee Coverage ☐ Lapse coverage during qualifying EH leave of absence ☐ Address Change ☐ Name Change; Previous Name: _____	☐ **ADD** Newly Acquired/Eligible Dependent(s) due to: ☐ Marriage ☐ Domestic Partnership ☐ Birth/ Adoption/ Legal Guardianship ☐ QMCSO ☐ Loss of Other Group Coverage ☐ Other _____ ☐ **Dropping** Dependent(s) due to ☐ Divorce/Legal Separation/Termination of Domestic Partnership ☐ Gaining Other Group Coverage ☐ Over-age Dependent ☐ Other _____

I ELECT THIS MEDICAL PLAN: (*Note* - If waiving or declining medical coverage, complete Acknowledgement on page 5 of this form)	**Check One:** ☐ Employee Only ☐ Employee + 1 ☐ Employee + 2 or more ☐ Waive Medical

☐ Kaiser Traditional HMO (602484-0003)	☐ Kaiser Hospital Services DHMO (602484-0006)	☐ Kaiser Deductible First HDHP (602484-0009)
☐ Sutter Health Plus HMO (131802-000001)	☐ Sutter Health Plus Hospital Services DHMO (131802-000005)	☐ Sutter Health Plus Deductible First HDHP (131802-000009)
☐ Western Health Advantage HMO (950201-A000)	☐ Western Health Advantage Hospital Services DHMO	☐ Western Health Advantage Deductible First HDHP

Sutter Health Plus (SHP) and Western Health Advantage (WHA) ONLY (If you do not provide a PCP ID # for yourself and your covered dependent(s), a Primary Care Physician will automatically be assigned. For PCP changes only, please contact the Health Plan directly.)	Primary Care Physician (PCP) ID #

Employee Name: ____________________

Employee ID: ____________________

ELIGIBLE DEPENDENT INFORMATION: List ALL person(s) to be covered

Spouse/Domestic Partner:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Child:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Child:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Child:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Child:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Child:

Last Name, First Name, MI	Medical	Check One	Date of Birth	Social Security (Required)	Relationship
	☐Add ☐Continue ☐Delete ☐Waive	☐ Male ☐ Female			

Mailing Address (If different from Employee)	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	Primary Care Physician ID #	Previously Seen
	☐ Yes ☐ No	☐ No ☐ Yes			☐ Yes ☐ No

Employee Name: _____

Employee ID: _____

SIGNATURE REQUIRED - Sign the applicable Agreement for the Health Plan Provider you selected. Failure to sign will result in no medical plan enrollment.

Kaiser Permanente Benefit Plan Agreement: Kaiser Permanente HMO, Kaiser Hospital Services Deductible DHMO, or Kaiser Deductible First HDHP

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

Employee Name: _____

Employee ID: _____

Sutter Health Plus Member Agreement: Sutter Health Plus HMO ML42 , Sutter Health Plus Hospital Services Deductible DHMO ML21, or Sutter Health Plus Deductible First HDHP HD01/HD51

BINDING ARBITRATION

Sutter Health Plus handles and resolves member disputes through grievance, appeal and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *Evidence of Coverage and Disclosure Form*.

Employee Signature	Date

Western Health Advantage Arbitration Agreement: Western Health Advantage HMO, Western Health Advantage Hospital Services DHMO, or Western Health Advantage Deductible First HDHP

Western Health Advantage Arbitration Agreement

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. **ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.**

Employee Signature	Date

Employee Authorization and Signature (Required)

I hereby elect the benefit plan(s) designated on page one of this form. I have also listed my eligible dependent(s) to be added to, or deleted from, the designated benefit plan(s). I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent.

I authorize my employer to deduct from my salary the amount required to cover my share of the premium payment (including any future premium increases). I agree for myself and my dependent(s), effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the applicable Group Agreement as it may be amended
- To authorize providers who have rendered services to me and my dependent(s) to make health information and records regarding those services available to the health plan and their providers who, in turn, may share such records among themselves.
- To complete and submit consents, releases assignments, and other documents related to protecting the health plan's rights under the Group Agreement. This includes coordinating benefits with other group health plans, insurance policies, Worker's Compensation, or Medicare. I also agree to pay the cost incurred by the health plan out of any awards, settlements, or payments made to me in connection with personal injuries sustained by me or my dependent(s).
- I certify each Social Security number listed on this application is correct.

I understand that I must complete a new **County of Sonoma Employee Benefits Enrollment/Change Form within 31 days** of a change in this qualification or a change of benefit eligibility. I understand that the employee portion of the benefit premiums will be pre-tax only for IRS Qualified dependents. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified.

I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature	Date

Waiver or Declination of Medical Plan Acknowledgment - You must complete this section if you are waiving or declining medical coverage for yourself and/or your eligible dependent(s).

If you wish to waive or decline coverage for yourself or your eligible dependents under County-offered medical plans, you must complete the information below. **To waive medical coverage, the individual must have other group coverage or coverage through Covered CA, otherwise the election is to decline coverage rather than waive.** Continuous coverage in other group insurance is a requirement for mid-year re-enrollment upon the loss of other group coverage or Covered CA.

☐ Waive Medical Coverage for Myself and any eligible Dependent(s)
☐ Waive Medical Coverage for my eligible Dependent(s)
☐ Decline Medical Coverage for Myself and any eligible Dependent(s)
☐ Decline Medical Coverage for my eligible Dependent(s)

By signing below, I acknowledge that I have been given the opportunity to enroll myself and my eligible dependents in a County-offered medical plan. I understand I will not be eligible to enroll in a County-offered medical plan until the plan's next annual enrollment period or in accordance with the loss of eligibility for other group coverage or coverage through Covered CA. If I become eligible to make a change during the plan year, I must request enrollment within 31 days of the qualifying event.

Employee Signature	Date

~ END OF EXTRA HELP EMPLOYEE MEDICAL PLAN ENROLLMENT/CHANGE FORM ~