



## COUNTY OF SONOMA EMPLOYEE SCLEA, SCLEMA AND SCPDIA EMPLOYEES MEDICAL PLAN ENROLLMENT/CHANGE FORM

 New Employee

 Change in Status - Adoption of Successor MOU May 24, 2016

 Annual Enrollment

I ELECT THIS MEDICAL PLAN										
<input type="checkbox"/> Kaiser Traditional HMO (602484-0003)		<input type="checkbox"/> Kaiser Hospital Services DHMO (602484-0006)		<input type="checkbox"/> Kaiser Deductible First DHMO (602484-0009)		<input type="checkbox"/> Sutter Health Plus HMO (131802-000001)				
<input type="checkbox"/> Western Health Advantage (950201-A000)		<input type="checkbox"/> County Health Plan EPO (175130-M100)		<input type="checkbox"/> County Health Plan PPO (175130-M051)						
EMPLOYEE INFORMATION					Office Use Only:	Medical Effective Date	HR Technician Initials	Date Entered into eP		
Last Name		First Name		Middle Name		FTE	Employee ID			
Social Security Number		Date of Birth	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Bargaining Unit			
Residential Address (Required)			<input type="checkbox"/> Check Box if new address		City		State	Zip Code		
Mailing Address			<input type="checkbox"/> Check Box if Same as Residential		City		State	Zip Code		
Personal Email Address		Work Phone		Personal Phone		Other Phone				
Sutter Health Plus (SHP) and Western Health Advantage (WHA) ONLY							Primary Care Physician (PCP) ID #			
(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.)										

<b>Check One:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + 2 or more		<b>ELIGIBLE DEPENDENT INFORMATION:</b> List ALL person(s) to be covered							
Last Name, First Name, MI	Action	Check One	Date of Birth	Social Security (Required)	Relationship	Permanently Disabled	IRS Qualified Dependent	SHP and WHA Enrollees ONLY	
								Primary Care Physician ID #	Previously Seen
Spouse/Domestic Partner:									
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:									
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive		<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

**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

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

**County Health Plan Agreement: County Health Plan PPO or County Health Plan EPO**

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement  
REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

Both parties to this contract, by entering into it, 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 arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

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

\_\_\_\_\_  
Date

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

Kaiser Foundation Health Plan, Inc., 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*.

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

\_\_\_\_\_  
Date

## Sutter Health Plus Member Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and Evidence of Coverage and Disclosure Form, upon completion and execution of this Enrollment Form.

### **BINDING ARBITRATION**

Sutter Health Plus (SHP) 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, SHP 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 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 medical plan designated on page one of this form. I have also listed my eligible dependent(s) to be added to, or deleted from, the designated medical plan. 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 medical information and records regarding those services available to the medical 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 medical plan's rights under the Group Agreement. This includes coordinating benefits with other group medical plans, insurance policies, Worker's Compensation, 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 dependent(s).

I understand that I must complete a new **County of Sonoma Medical Plan 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