COUNTY OF SONOMA EMPLOYEE
BENEFITS ENROLLMENT/CHANGE FORM

☐ Annual Enrollment ☐ New Hire/Newly Eligible Date _____ ☐ Change in Status Date _____

FOR COUNTY USE ONLY:

Benefits Effective Dates:

Medical Eff. Date of Enrollment or Change _____
Dental Eff. Date of Enrollment or Change _____
Vision Eff. Date of Enrollment or Change _____
Basic Life Eff. Date of Enrollment or Change _____
Dep. Life Eff. Date of Enrollment or Change _____
Date entered in eP: _____
HR Technician Initials: _____

SECTION I: EMPLOYEE INFORMATION

Last Name	First Name	Middle Name	FTE	Employee ID

Social Security Number	Date of Birth	Check One	Marital Status	Bargaining Unit
		☐ Male ☐ Female	☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Widowed	

Residential Address (Required) ☐ Check Box if new address	City	State	Zip Code

Mailing Address ☐ Check Box if Same as Residential	City	State	Zip Code

Work Email Address	Personal Email Address	Work Phone	Personal Phone	Other Phone

SECTION 1A: Reason for Enrollment/Change
Check ALL Boxes that apply

☐ Annual Enrollment
☐ New Hire
☐ Newly Eligible Employee
  ☐ Extra Help to Probationary
  ☐ _____ FTE to _____ FTE
  ☐ Other _____
☐ Bargaining Unit Change
  Old BU _____ New BU _____
☐ Loss of Other Group Coverage
☐ Reenrollment/Reinstatement
☐ Cancel Employee Coverage
☐ Address Change
☐ Name Change; Previous Name: _____

SECTION 1B: Add/Drop/Waive Dependent Coverage
Check ALL Boxes that apply

☐ **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 _____

SECTION II: ELECT A MEDICAL PLAN OR WAIVE MEDICAL COVERAGE

County Health Plans

☐ County Health Plan **EPO** (175130-M100)
☐ County Health Plan **PPO** (175130-M051)

Kaiser Permanente Plans

☐ Kaiser Traditional **HMO** (602484-0003)
☐ Kaiser Hospital Services **DHMO** (602484-0006)
☐ Kaiser Deductible First **DHMO** (602484-0009)

Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Participants: Select a Primary Care Physician (PCP) for yourself, and enter your PCP's ID # below. Select a Primary Care Physician for each dependent and enter your dependent's PCP ID # in Section IV: Dependent Information.

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.

Sutter Health Plus Plan – Select a Primary Care Physician (PCP) & Provide PCP ID #	
☐ Sutter Health Plus **HMO** (XXXXXXXXXXXX) **Primary Care Physician (PCP) ID #**	• **To find a PCP please visit: www.sutterhealthplus.org/providersearch** • If you do not select a PCP, one will be assigned to you • You have the opportunity to change your PCP by calling Member Services at **1-855-315-5800**
Western Health Advantage Plan – Select a Primary Care Physician(PCP) and Provide PCP ID #	
☐ Western Health Advantage **HMO** (XXXXXXXXXXXX) **Primary Care Physician (PCP) ID #**	• **To find a PCP please visit: www.westernhealth.com/search-for-providers** • If you do not select a PCP, one will be assigned to you. • You have the opportunity to change your PCP by calling Member Services at **888-563-2250**

Waive Medical Coverage –Must also Sign Waiver of Medical Plan Acknowledgement (Section VI)

To waive medical coverage for yourself and/or your eligible dependent(s), the individual must have other group coverage or coverage through Covered CA, otherwise the election is to Decline coverage rather than to waive.

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

☐ Waive Medical Coverage for my eligible Dependent(s)

Decline Medical Coverage

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

SECTION III: SELECT MEDICAL LEVEL OF COVERAGE

☐ Self ☐ Self + 1 Dependent ☐ Self + 2 or More Dependents (Family)

SECTION IV: SELECT A DENTAL PLAN OR WAIVE DENTAL COVERAGE

Delta Dental Premier

☐ Self ☐ Family ☐ Continue current enrollment ☐ Waive (Other group coverage) ☐ Decline

SECTION V: LIFE INSURANCE (Hartford Policy #GL-673199) *Provided to employees with an FTE of .75 or greater (60 hours or more bi-weekly). Available for purchase by part -time employees in some bargaining units. Complete this section as indicated in the instructions form.*

Basic Life Insurance

Initial here _____ if you have a beneficiary designation on file with the County of Sonoma and do not wish to update it. (New Hires are required to complete the beneficiary designation below versus initialing.)

Basic Life Insurance coverage is provided to eligible employees at no cost. If eligible, you are automatically enrolled. You must designate a beneficiary to receive payment of this benefit in the event of your death. Indicate your beneficiary information below, only if you do not currently have a beneficiary on file or you wish to change your current beneficiary designation. All newly eligible employees must provide beneficiary information. If you need more space, request a Beneficiary Designation Form from the Human Resources Benefits Unit or go online to the Human Resources Benefits site http://hr.sonoma-county.org/documents/HartfordGroupBeneficiaryDesignationForm.pdf or through ESS (Employee Self-Service).

	Full Name	Birth Date	Address	SSN	% of Benefit
Primary Beneficiary					

Contingent Beneficiary	Full Name	Birth Date	Address	SSN	% of Benefit

This designation applies to your Basic Life Insurance benefit only; it can be changed at any time. If you are married or divorced, consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date the completed form is received and accepted by the County.

Basic Life Ins. – Part-Time Employee's in limited Bargaining Units

☐ I am in an eligible bargaining unit [DSA (46, 47), SCLEA (30, 40, 41, 70), or ESC (75)] and I am electing to

☐ **ENROLL** ☐ **CONTINUE** basic employee life insurance at my own expense.

☐ I am electing to **DROP** basic employee life insurance

Supplemental Life Insurance (Available for purchase to employees enrolled in Basic Life Insurance)

To apply for or change your coverage level or beneficiary, contact the Human Resources Benefits Unit or go online to the Human Resources Benefits site for the Supplemental Life Insurance Enrollment Form http://hr.sonoma-county.org/documents/Hartford-Supplemental-Life-Insurance-Form.pdf .

Dependent Life Insurance (If coverage is elected, enter your dependent information below) You may purchase dependent life insurance for your spouse, domestic partner, and eligible dependent children below. Indicate your election to purchase this coverage.

☐ Add Dependent Life	☐ Continue Dependent Life	☐ Decline Dependent Life	☐ Waive Dependent Life

SECTION VI: ELIGIBLE DEPENDENT INFORMATION

Spouse/Domestic Partner

☐ Add Medical Coverage	☐ Continue Medical Coverage	☐ Decline Medical Coverage	☐ Waive Medical Coverage (Must have other group coverage or coverage through Covered CA)
☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	

Last Name:	First Name:	Middle:

Relationship: (Check one) ☐ Spouse ☐ Domestic Partner	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified	Permanently Disabled: (Check one) ☐ Yes ☐ No

Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No	☐ Male ☐ Female

Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No	

Residential Address: ☐ Check Box if Same as Employee's	City:	State:	ZIP:
Mailing Address (Only if Different than Employee's)	City:	State:	ZIP:

Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Coverage; Select a Primary Care Physician (PCP) and enter the PCP ID # below.

Primary Care Physician (PCP) ID #	

If you do not provide a PCP ID # for your covered dependent(s), a Primary Care Physician will automatically be assigned

Dependent

☐ Add Medical Coverage	☐ Continue Medical Coverage	☐ Decline Medical Coverage	☐ Waive Medical Coverage (Must have other group coverage or coverage through Covered CA)
☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	

Last Name:	First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified	Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No / ☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No		

Residential Address: ☐ Check Box if Same as Employee's	City:	State:	ZIP:
Mailing Address (Only if Different than Employee's)	City:	State:	ZIP:

Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Coverage; Select a Primary Care Physician (PCP) and enter the PCP ID # below.

Primary Care Physician (PCP) ID #	

If you do not provide a PCP ID # for your covered dependent(s), a Primary Care Physician will automatically be assigned

Dependent

☐ Add Medical Coverage	☐ Continue Medical Coverage	☐ Decline Medical Coverage	☐ Waive Medical Coverage (Must have other group coverage or coverage through Covered CA)
☐ Add Dental Coverage	☐ Continue Dental Coverage	☐ Decline Dental Coverage	☐ Waive Dental Coverage (Must have other group coverage)
☐ Add Vision Coverage	☐ Continue Vision Coverage	☐ Decline Vision Coverage	☐ Waive Vision Coverage (Must have other group coverage)
☐ Add Dependent Life Insurance	☐ Continue Dependent Life Insurance	☐ Decline Dependent Life Insurance	

Last Name:	First Name:	Middle:
Relationship:	For Tax Purposes Only: (Check one) ☐ IRS Qualified ☐ Non IRS Qualified	Permanently Disabled: (Check one) ☐ Yes ☐ No
Date of Birth:	Social Security (required):	Is this person a County of Sonoma Employee or Retiree? ☐ Yes ☐ No / ☐ Male ☐ Female
Is Dependent a full time Student? (may be required for vision enrollment age 19-23 - check MOU) ☐ Yes ☐ No		

Residential Address: ☐ Check Box if Same as Employee's	City:	State:	ZIP:
Mailing Address (Only if Different than Employee's)	City:	State:	ZIP:

Sutter Health Plus (SHP) Plan and Western Health Advantage (WHA) Plan Coverage; Select a Primary Care Physician (PCP) and enter the PCP ID # below.

Primary Care Physician (PCP) ID #	

If you do not provide a PCP ID # for your covered dependent(s), a Primary Care Physician will automatically be assigned

SECTION VII: SIGNATURE REQUIRED-
(Sign the Agreement for the Health Plan Provider Selected in Section II)

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 _____

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

If you wish to waive 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.

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 _____

Section IX: Employee Authorization and Signature (Required)

I agree to comply with the terms of the benefits group contracts in which I am enrolled. 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 will 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 authorize the County of Sonoma to withhold insurance premiums for the benefits requested in this document in accordance with the applicable Memorandum of Understanding or Salary Resolution. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature _____ Date _____