Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

ESSENTIAL HEALTH PLAN COVERAGE ENROLLMENT/CHANGE FORM

Must print in Blue or Black ink ONLY

☐ New Employee ☐ Open Enrollment ☐ Change in Status

☐ I elect to enroll in Essential Health Plan Coverage (AKA Blue Shield Bronze Plan)

Employee Information			
Employee ID	Last Name, First Name, MI	Social Security Number	Date of Birth
Department		Check One	Telephone
		☐ Male ☐ Female	
Mailing Address *(Street, City, State, Zip)*			☐ Check box if new address
Residential Address *(Street, City, State, Zip)*			☐ Check box if new address

ENROLLMENT INFORMATION	IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME, CHANGING PLANS, OR ADDING/DELETING DEPENDENT(S) , LIST ALL PERSON(S) TO BE COVERED AND PROVIDE APPROPRIATE DOCUMENTATION FOR EACH

	Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Disabled?	Relationship
☐ Add ☐ Delete		☐ Male ☐ Female			☐	Spouse/Domestic Partner
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	
☐ Add ☐ Delete		☐ Male ☐ Female			☐	

OTHER MEDICAL COVERAGE	**MEDICARE COVERAGE**	
Are you or any member of your family covered by other group medical insurance? ☐ Yes ☐ No	List all family members enrolled in both parts A & B of Medicare:	
Insurance Company	Name (last, first, middle)	
Policy No.	ID No.	Date of Birth
Spouse/Domestic Partner's Employer	Name (last, first, middle)	
Phone Number	ID No.	Date of Birth

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BLUE SHIELD DISCLOSURE

Authorization
The following authorization section is to be signed by all employees 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misrepresentation of any material fact that my coverage may be cancelled or, following notice, my employer's contract rescinded. I further authorize my employer to deduct from my earning contribution (if any) required towards the cost of this plan.

I understand that coverage does not become effective until this and my employer'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.

QUALIFYING CHANGE IN STATUS EVENT

I understand that I may elect to add or delete eligible dependent(s) to my medical plan if a "Qualifying Change in Status Event" occurs.
Examples of qualifying events are:

- Marriage, domestic partnership, divorce, dissolution of domestic partnership or legal separation 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 (disabled child over age 26)
- Unpaid leave of absence taken by the member's spouse or domestic partner
- A significant change in the medical coverage of the member or dependent(s) attributable to the spouse's/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 dependent(s), I understand that I must submit a new Essential Health Plan Coverage Form and a Premium Deduction Election Form within 60 days of a Qualifying Change in Status Event. If I do not submit these forms within 60 days, my request may be denied. All requests must be consistent with the stated qualifying event.

I understand that if at any time my or my family's eligibility changes, I will notify HR-EBSD or department payroll specialist within 60 days of the change in order to make the appropriate changes to my benefit deductions. For example, if I get divorced I am required to remove my ex-spouse from County-sponsored Benefit Plans.

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 Employee 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 and intranet sites.
- 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 inconsistencies discovered with respect to enrollment and eligibility will be investigated and I may be subject to disciplinary action up to and including termination of employment.
- 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 dependent's 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. Additionally, I will reimburse the County for any portion of the employer contribution paid to the carrier(s) for the period of time coverage was provided for my ineligible dependent.
- 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 this form, I certify and affirm to San Bernardino County that the dependent(s) 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, applicable Memoranda of Understanding, and related state and/or federal law(s).

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AGREEMENT

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 certify that any eligible dependent children I am adding to the designated medical plan are not eligible for other group health plan coverage.

I authorize my employer to deduct from my salary the amount required to cover my share of the 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 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 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. 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 dependent(s).

I acknowledge and understand that health care providers may disclose health information about me or my dependent(s), 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.

Employee Name (Print & Sign)	Date
Payroll Specialist Name (Print & Sign)	

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

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FOR HR USE ONLY			
Keyed By (Employee ID)	Date	Pay Period Effective	Effective Date