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

MEDICAL PLAN ENROLLMENT/CHANGE FORM

Must print in Black or Blue ink ONLY

☐ New Employee ☐ Change in Status ☐ Open Enrollment

I ELECT THIS MEDICAL PLAN ☐ Kaiser HMO ☐ Kaiser Choice HMO ☐ Kaiser Virtual Complete HMO ☐ BS Virtual Blue Needles PPO
☐ Blue Shield Signature HMO ☐ Blue Shield Access+ HMO ☐ Blue Shield Gold Trio HMO ☐ Blue Shield PPO ☐ Blue Shield Needles PPO

EMPLOYEE INFORMATION

Employee ID	Last Name, First Name, MI	Social Security Number	Check One ☐ Male ☐ Female	Date of Birth

Mailing Address	Check box if new address ☐	City	State	Zip Code	Telephone
Residential Address	**Check box if new address ☐**	**City**	**State**	**Zip Code**	**Date of Hire**

Department	Group ID No. & Physician ID No. *(Blue Shield HMO Plans Only)*	Previously Visited? ☐ Yes ☐ No

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 AND PROVIDE APPROPRIATE DOCUMENTATION FOR EACH

BLUE SHIELD SIGNATURE HMO, TRIO HMO & ACCESS+ HMO ENROLLEES ONLY

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

ENROLLMENT CHANGES ONLY — IF YOU ARE ADDING OR DELETING DEPENDENT(S) BUT NOT CHANGING PLANS, COMPLETE THIS SECTION AND PROVIDE APPROPRIATE DOCUMENTATION

BLUE SHIELD SIGNATURE HMO, TRIO HMO & ACCESS+ HMO ENROLLEES ONLY

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

IF ADDING SPOUSE/DOMESTIC PARTNER, INDICATE DATE OF MARRIAGE/ DOMESTIC PARTNERSHIP. IF DELETING, INDICATE DATE OF DIVORCE/ DISSOLUTION OF DOMESTIC PARTNERSHIP OR DEATH	Month	Day	Year	☐ Married/Domestic Partnership ☐ Divorce/Dissolution of Domestic Partnership ☐ Death

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

ENROLLED DISABLED DEPENDENTS	
List the names of any disabled dependents you are enrolling below:	
Last Name, First Name, MI	Last Name, First Name, MI
Last Name, First Name, MI	Last Name, First Name, MI
Last Name, First Name, MI	Last Name, First Name, MI

KAISER PERMANENTE MEMBERS ONLY

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.

Employee Signature	Date

BLUE SHIELD MEMBERS ONLY

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 our 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.

NEEDLES SUBSIDY ELIGIBLE EMPLOYEES

I understand that my eligibility for the "Needles Subsidy" is entirely contingent upon being assigned to Needles, Trona, or Baker as my work location. I understand that it is my responsibility to notify the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) should my assigned work location change to an area other than Needles, Trona, or Baker. I further understand that should it be discovered that the Needles Subsidy has been paid to me in error, the County will collect, through payroll deduction, any amount of subsidy for which I received and was not eligible.

Employee Signature	Date

QUALIFYING CHANGE IN STATUS EVENT

I understand that I may elect to add or delete eligible dependents(s) to my medical plan is 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 significant increase or decrease in premium cost
- Medicare entitlement

To add or delete dependent(s), I understand that I must submit a new Medical Plan Enrollment/Change Form within 60 days of a Qualifying Change in Status Event. If I do not submit this form 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, applicable Memoranda of Understanding, 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.
- he County reserves the right to request adequate documentation to asses 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. 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 assure any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, 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, term of benefit plan contracts, County policies, applicable Memoranda of Understanding, and related state and/or federal laws.

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 Signature	Date

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