County of Sonoma *RETIREE* Benefits Enrollment/Change Form

Instructions for Completing This Form

****Remove staple. Please complete each form separately to avoid imprinting through to other forms.**** ***You must complete all sections of the form.***

Section 1: Reason for Submitting Form

- Use this form to enroll for coverage during annual enrollment, as a newly eligible retiree, or to change your current coverage due to a qualifying change of status event.
- Indicate the reason you are submitting the form and the effective date of the event that led to the change(s), as necessary (e.g. date of marriage, date of retirement). Mark all boxes that apply.
- Newly eligible dependents may only be enrolled within 31 days of the eligibility event.

Section 2: Personal Information

Fill in all information requested. If your spouse/domestic partner/dependent(s) is employed by or retired from the County of Sonoma, please mark the appropriate box(es) on the form. Dual coverage in County sponsored health plans is prohibited.

Section 3: Medical Plan Election

- Indicate whether you wish to make an annual enrollment change, enroll as a newly eligible retiree, add coverage for newly eligible dependent(s), continue current enrollment in medical coverage for yourself and/or your dependent(s), or waive, drop/cancel medical coverage for yourself and/or your eligible dependent(s).
- Select your coverage level and medical plan. If enrolling in a County Health Plan, choose a California or Out of State plan based on the location of your residence for the majority of the year.
- If enrolling in one of the Kaiser or UHC AARP Medicare plans, also complete applicable enrollment/change forms for the plan.
- Complete the *Kaiser Foundation Arbitration Agreement* (Section 8 of this form) if you are enrolling in any Kaiser Permanente plan.
- If applicable, list all eligible dependents including spouse / domestic partner (Section 6 of this form). List any dependent who is being added, dropped, waived, or continuing coverage.

Section 4: Dental Plan Election

- Select DeltaCare USA (California Only) or Delta Dental PPO for your dental plan. If enrolling in DeltaCare USA, please provide the Contract Facility Name and Number information.
- Indicate whether you wish to make an annual enrollment election, enroll as a newly eligible retiree, add coverage for newly eligible dependent(s), continue current enrollment in dental coverage for yourself and/or your eligible dependent(s), or drop dental coverage for yourself and/or your dependent(s).

Section 5: Life Insurance

Complete this section ONLY to:

- Life insurance enrollment is only available at the time of retirement. If you did not enroll at that time, you are not eligible to enroll at a later date, including during annual enrollment.
- Indicate whether you wish to enroll as a newly eligible retiree, continue current enrollment at the same level, exercise your one time option to increase your coverage from $2,000 to $10,000, or drop life insurance coverage.
- Designate a primary and/or contingent beneficiary(ies) for your life insurance or change your previous designation on file.
- Initial in the space provided if you have a life insurance beneficiary designation on file with the County of Sonoma and do not wish to update it.

Section 6: Eligible Dependent Information

- Complete the information by listing your dependents and their coverage status in medical and dental coverage. Indicate **(A)** to add coverage for an eligible dependent(s); **(C)** to continue enrollment in coverage for an eligible dependent(s); **(D)** to drop coverage for ineligible dependent(s); **(W)** to waive coverage for an eligible dependent(s); or **(X)** to permanently cancel coverage for dependents who are not eligible to waive.
- You MUST indicate for each dependent whether each is a full-time student, permanently disabled, and/or considered IRS-qualified.
- Indicate whether you and/or your dependents have medical coverage in addition to County-offered coverage (e.g. through your spouse/domestic partner's employer). If so, provide the coverage information requested. This information is required for coordination of benefits.

Section 7: Retiree Authorization and Signature

- Review the Retiree Authorization Agreement and sign and date your form.

Section 8: Benefit Plan Provider Agreements

- Sign the County Health Plan Arbitration Agreement (Section 8).

Section 9: Benefit Plan Provider Agreements

- Sign the Kaiser Foundation Health Plan Arbitration Agreement (Section 9).

When Changes are Allowed

Your benefits elections for the plan year are irrevocable with a few limited status change exceptions. Make benefit elections carefully and contact the County of Sonoma Human Resources Benefits unit at benefits@sonoma-county.org or (707) 565-2900 with any questions.

Please make a copy of this form for your records and return the original Enrollment/Change form to the County of Sonoma Human Resources Department by the enrollment deadline.

575 Administration Dr., Ste #116C, Santa Rosa, CA 95403

County of Sonoma *RETIREE* Benefits Enrollment/Change Form

Confidential Information

All retirees must complete all sections of the form. Please follow the instructions on the front cover before completing this form.

Section 1a: Reason for Enrollment/Change

Mark all boxes that apply and enter date:

Event Date: _____

- ❑ Annual Enrollment (Event date: June 1)
- ❑ New Retiree
- ❑ Newly Medicare Eligible Retiree
- ❑ Loss of Other Group Coverage
- ❑ Moved Out of Service Area
- ❑ Cancel Coverage (Irrevocable)
- ❑ Life Insurance Beneficiary Change
- ❑ Address Change
- ❑ Name Change

Previous Name: _____

Section 1b: Add/Drop Dependent Coverage

Mark all boxes that apply and enter date:

Event Date: _____

❑ **ADD** Newly Acquired/Eligible Dependent(s) due to:
❑ Marriage ❑ Domestic Partnership
❑ Birth ❑ Adoption ❑ Legal Guardianship ❑ QMCSO
❑ Loss of Other Group Coverage ❑Medicaid ❑Medicare
❑ Dependent(s) newly eligible for ❑Medicaid ❑Medicare

❑ **DROP/WAIVE** Dependent(s): _____
Reason_____

Initial here_____ if dropping coverage for an eligible dependent while retiree remains enrolled. County policy, Salary Resolution, 95-0926, prohibits future re-enrollment of a dependent child.

Internal / Vendor Use Only

Benefits Effective Date: _____

Medicare: ❑ YES ❑ NO

Retiree Medical Eligibility:
❑ Post '90 10-20 ❑ Post '90 20+
❑ Pre 1990 ❑ Post 2009

Eligible Dependents @ Full Cost: _____

Waiver Received: ❑ YES ❑ N/A
HR Initials:_____ **Date:** _____

eP Entry: _____Review: _____

Section 2: Retiree's Personal Information

Last Name | **First Name** | **M.I.** | **Social Security Number**

Home Address | **City, State, Zip Code** | **Date of Birth (MM-DD-YY)**

Phone Number(s) | **E-mail**

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Domestic Partner

Is your spouse/domestic partner/dependent(s) an employee of the County of Sonoma?
❑ Yes ❑ No If yes, list name(s): _____

Is your spouse/domestic partner a retired employee of the County of Sonoma?
❑ Yes ❑ No If yes, list name(s): _____

Gender (Retiree): ❑ Male ❑ Female

Section 3: Medical Plan Election *(Check all that apply; complete Section 6 if enrolling eligible dependents.)*

Mark all boxes that apply.

- ❑ **ANNUAL ENROLLMENT CHOICE ONLY-**I am electing to **CHANGE MY MEDICAL PLAN ELECTION.**
- ❑ I am a **NEWLY ELIGIBLE RETIREE** making my medical plan election.
- ❑ I am electing to **ADD** medical coverage for my newly eligible dependent(s).
- ❑ I am electing to **CONTINUE** current enrollment in retiree medical coverage for myself and/or my eligible dependent(s).
- ❑ I am electing to **WAIVE** medical coverage for myself and/or my dependent(s) as I/we have other group coverage.
  By waiving, I will not have the option of re-enrollment at anytime unless I qualify under the limited provisions as defined in the Salary Resolution 95-0926.
  If waiving medical coverage for yourself and/or your eligible dependent(s), you must also complete the Waiver of Medical Plan Acknowledgement (Section 9).
- ❑ I am electing to **DROP/CANCEL** medical coverage for myself and/or my dependent(s). (Applies to a current retiree not eligible to waive medical coverage).
  I understand that by cancelling my medical coverage, I forfeit my opportunity to enroll in a County offered medical plan in the future.

Select your Level of Coverage and Medical Plan

Level of Coverage: ❑ **SELF** ❑ **SELF + 1 DEPENDENT** ❑ **SELF + 2 OR MORE DEPENDENTS**

Retirees without Medicare:

- ❑ County Health Plan PPO - CA (175130M053)
- ❑ County Health Plan PPO - Out of State (175130M059)
- ❑ County Health Plan EPO - CA (175130M102)
- ❑ County Health Plan EPO - Out of State (175130M106)
- ❑ Kaiser Permanente HMO - CA (9072-0000)
- ❑ Kaiser Permanente HMO - Northwest (5613-002 AA)
- ❑ Kaiser Permanente HMO - Hawaii (03003-058-86)

Retirees with Medicare:

- ❑ County Health Plan PPO - CA (175130M054)
- ❑ County Health Plan PPO - Out of State (175130M060)
- ❑ County Health Plan EPO - CA (175130M103)
- ❑ County Health Plan EPO - Out of State (175130M107)
- ❑ Kaiser Permanente Senior Advantage - CA (9072-0000) *
- ❑ Kaiser Permanente Senior Advantage - Northwest (5613-002 AA)*
- ❑ Kaiser Permanente Senior Advantage - Hawaii (03003-058-86) *
- ❑ UnitedHealthcare AARP Medicare Supplement (1068) * and Medicare Rx (3803) *

***Additional Enrollment Form Required**

Section 4: Dental Plan Election *(Check all that apply; complete Section 6 if enrolling eligible dependents.)*

Select your dental plan choice: ❑ **Delta Preferred Option** (3136-0001)

❑ **DeltaCare USA** (0247-0001)-Enter contract facility name & number below

Contract Facility Name: _____ Facility #: _____

Mark all boxes that apply.

❑ **ANNUAL ENROLLMENT** choice only-I am electing to **CHANGE** my dental plan election**.**

❑ I am a **NEWLY ELIGIBLE RETIREE** making my dental plan election.

❑ I am electing to **ADD** dental coverage for my newly eligible dependent(s).

❑ I am electing to **CONTINUE** current enrollment in dental coverage for myself and/or my eligible dependent(s).

❑ I am electing to **DROP** dental coverage for myself and/or my dependent(s).

Internal Use Only

Effective Date: _____

If blank, effective date is the same as Benefits Effective Date on Page 1.

Section 5: Life Insurance *(Complete this section as instructed on the cover of this form.)*

HARTFORD GROUP POLICY #: GL-673199

❑ I am a **NEWLY ELIGIBLE RETIREE** electing to **ENROLL** in life insurance coverage in the amount of $10,000

❑ I am electing to **CONTINUE** my current enrollment in life insurance coverage in the amount of $2,000

❑ I wish to exercise my one-time option during the 2011 **ANNUAL ENROLLMENT** to **CHANGE** my current enrollment in life insurance coverage from $2,000 to $10,000

❑ I am electing to **DROP** current enrollment in life insurance coverage

❑ I did not enroll in life insurance at the time I retired and am therefore **NOT ELIGIBLE** to make any life insurance election

Retiree Basic Life Insurance (**Initial here _____ if you have a life insurance beneficiary designation on file with the County of Sonoma and do not wish to update it.)**

You must designate a beneficiary(ies) 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. If you need more space, request a Beneficiary Designation Form from Hartford Life at 800-523-2233 or from County of Sonoma Human Resources Benefits Unit at 707-565-2900 or Benefits@sonoma-county.org

Primary Beneficiary Full Name	Address	SSN	% of Benefit	Relationship	Birth Date
Contingent Beneficiary Full Name (Optional)	**Address**	**SSN**	**% of Benefit**	**Relationship**	**Birth Date**

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 of Sonoma Human Resources Department.

Section 6: Eligible Dependent Information *(List ALL eligible dependents including spouse/domestic partner. Attach an additional sheet to list more than six dependents.)*

Full-time student status is required to enroll dependents 19 and over in County-offered dental coverage. Disabled over-age dependents must meet the eligibility requirement for permanently disabled over-age dependent(s). Refer to the plans' evidence of coverage booklets or summary plan descriptions for more information. *Complete the information below and indicate your choice for your dependent(s).* ***A****=Add coverage,* ***C****=Continue enrollment in coverage,* ***D****=Drop coverage,* ***W****=Waive coverage, or* ***X****= Cancel coverage*

Dependent Name (First, MI, Last)	**Relationship to Retiree**	**Social Security Number**	**Date of Birth (MM-DD-YY)**	**Gender (M/F)**	**Enroll in Medical Coverage? (Enter A, C, D, W, or X)**	**Enroll in Dental Coverage? (Enter A,C, or D)**	**Full-Time Student? (Y/N)**	**Permanently Disabled Dependent? (Y/N)**	**Tax Purposes Only Place a ✓ below to indicate dependent status**	
									IRS Qualified	**Non-IRS Qualified**

This information is required for coordination of benefits. Do you and/or your eligible dependents listed above have medical coverage in addition to County-offered coverage (e.g., through your spouse/domestic partner's employer or an individual policy?) ❑ Yes ❑ No If yes, enter the coverage information below.

Individual's Name	**Subscriber's Name**	**Name of Medical Plan**

Section 7: Retiree Authorization and Signature

I declare under penalty of perjury that:
I agree to comply with the terms of the benefits group contracts in which I am enrolled. I authorize the Sonoma County Employees' Retirement Association (SCERA) to withhold all insurance premiums in excess of any County contribution for the benefits requested in accordance with the applicable Board of Supervisor's Resolution. All eligible dependents listed meet the medical plan's eligibility requirements. I will complete a new Medical Benefits Enrollment/Change Form within 31 days of a change in benefit eligibility. I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge. I authorize SCERA to release to the County of Sonoma all information reasonably necessary to evaluate or administer my retiree health benefits.

Retiree Waiver Policy Acknowledgement
Retiree medical coverage provisions are outlined the County of Sonoma Salary Resolution No 95-0926. In order to maintain eligibility for a County contribution and to participate in a County-offered retiree medical plan, an eligible retiree must enroll in a County offered retiree medical plan at the time of retirement unless the retiree waives medical insurance coverage for themselves and/or the retiree's eligible dependent(s). The option to waive coverage is a onetime option available only at the time of retirement or upon initial eligibility for newly eligible dependents. A retiree who waives medical coverage will be allowed to re-enroll themselves and any eligible dependent(s), upon a limited number of conditions, has no annual enrollment rights, and is only eligible to waive if covered by another group medical plan. If not covered by another group medical plan, the retiree may drop/cancel coverage with no re-enrollment options.
By signing below, I acknowledge that I have been given the opportunity to enroll or waive coverage for myself and my eligible dependents listed in Section 6 in a County-offered medical plan pursuant to the eligibility criteria outlined in the Salary Resolution and the medical plan's documents. I understand I will be allowed to enroll myself and/or my eligible dependents in a County offered retiree medical plan, if eligibility requirements are met, and I enroll and submit documentation within 31 days of the event and no later than 60 day after becoming Medicare eligible. I acknowledge my eligible dependent child(ren) will only be allowed to re-enroll at the time I re-enroll.
If I become eligible to make a change during the plan year, I must request the change within 31 days of the event.

_____ ___ _____

Retiree Signature **Date**

Section 8: County Health Plan Agreement *(If electing one of the County Health plans, sign this agreement.)*

County Health Plan PPO, County Health Plan EPO

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

The following provision does not apply to class actions: 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. 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 provided by California law, 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 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.

_____ _____

Retiree Signature Required for County Health Plan **Date**

Section 9: Kaiser Permanente Plan Agreement *(If electing Kaiser, sign this agreement.)*

Kaiser Permanente Plan

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.*

_____ _____ _____

Retiree Signature Required for Kaiser Permanente HMO Plan – California Retirees Only **Date**