County of Sacramento, Employee Benefits Office
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EMPLOYEE BENEFITS ENROLLMENT FORM

1 EMPLOYEE INFORMATION | **EVENT:** | **Date of Event:**

Last Name | First Name | M.I. | Employee Pin | Date of Hire | ☐M ☐F

Physical Address | City | State | Zip

2 MEDICAL COVERAGE ☐ ENROLL ☐ WAIVE

	Kaiser Permanente	Western Health Advantage	Sutter Health Plus
☐Tier A ☐Tier B*(Irrevocable) ☐Employee Only ☐ Employee + Family	☐ HMO ☐High Deductible HMO	☐HMO ☐ High Deductible HMO	☐HMO ☐ High Deductible HMO

3 DENTAL COVERAGE ☐Employee Only ☐ Employee + Family

4 VISION COVERAGE Leave blank if enrolling in HMO plan ☐WAIVE ☐Employee Only ☐ Employee + Family

5 LIFE INSURANCE ☐Enroll Optional ☐Waive Optional

☐ OptA-1x salary 50k max ☐Option B-1x salary ☐Option C-2x salary ☐Option D-3x salary ☐Option E-4x salary

Complete the beneficiary form to designate your beneficiary(ies)

6 PRE-TAX ACCOUNTS

☐Health Savings Account (HSA) $_____ ☐Under 55 ☐Over 55

☐Medical Reimbursement Account $_____ ($2500 max)

☐Dependent Care Account $_____ ($5000 max)

7 ENROLLMENT INFORMATION—List all family members who should have coverage

	Last Name: / First Name:	M.I.	SSN: / DOB:	☐M ☐F	Dr: / Group:	Provider ID Number	Existing? ☐Y ☐N	Med	Dental	Vision	Life
You								☐	☐	☐	
SP / DP ☐Add ☐Drop								M ☐	D ☐	V ☐	L ☐
Ch1 ☐Add ☐Drop								M ☐	D ☐	V ☐	L ☐
Ch2 ☐Add ☐Drop								M ☐	D ☐	V ☐	L ☐
Ch3 ☐Add ☐Drop								M ☐	D ☐	V ☐	L ☐
Ch4 ☐Add ☐Drop								M ☐	D ☐	V ☐	L ☐

TURN OVER FOR AUTHORIZATION AND AGREEMENT, FORM NOT VALID UNLESS SIGNED BY EMPLOYEE **OVER →**

BINDING ARBITRATION 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.

WESTERN HEALTH ADVANTAGE

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:__________________

KAISER FOUNDATION HEALTH PLAN: 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, or any 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 (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.

____________________ (Initial)

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AUTHORIZATION All information on this form is true and correct; I understand that it is the basis on which coverage may be issued under the plan(s). Any dependents listed are my lawful spouse/domestic partner/and children, and are eligible for enrollment as my dependents. Any misstatements or omissions may result in disciplinary action and/or future claims being denied and/or the policy being rescinded. My signature indicates my acceptance of the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, benefit coverage, and all associated policies and procedures. If applicable, I authorize my employer to deduct from my wages the required premiums.

*TIER B: I understand this election is irrevocable and forfeits all entitlements to cashback and PSI. _______________ (Initial)

Employee Signature____ Date____________________________

OFFICE USE ONLY	Rate Change? ☐Y ☐N	Effective Date Of Change	Group Number	Accepted By--Benefits Staff Representative:	Date
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