County of Sacramento, Employee Benefits Office
700 H Street, Room 4667, Sacramento, CA 95814

RETIREE OPEN ENROLLMENT Form due by 10/30/2020

DATE STAMP AREA

☐ Adding Dependent(s)
☐ Dropping Dependent(s)
☐ Changing Plans
☐ Adding/Waiving Medical
☐ Adding/Waiving Dental
☐ Adding/Waiving Vision

916.874.2020 **PHONE**
916.874.4621 **FAX**
MyRetireeBenefits@saccounty.net **EMAIL**
http://www.personnel.saccounty.net/Benefits **WEB**

1 RETIREE

Last Name	First Name		M.I	Phone
Address	City	ST	Zip	Email

2 MEDICAL COVERAGE

☐ ENROLL ☐ WAIVE | ☐ Retiree ☐ Retiree +1 Dependent ☐ Retiree +2 or more dependents

NON-MEDICARE PLANS	MEDICARE PLANS	Do you have Medicare A & B ☐Y ☐N	Does your spouse have Medicare A & B ☐Y ☐N
Choose your carrier: ☐ Kaiser Permanente	☐ Kaiser Silver	Medicare ID	Medicare ID
☐ Western Health Advantage	☐ Kaiser Gold	________--_______--_________ ___	________--_______--_________ ___
☐ Sutter Health Plus	☐ United Healthcare HMO	Part A Effective Date:	Part A Effective Date:
☐ Split* ☐ HMO ☐ High Deductible	☐ United Healthcare NPPO	Part B Effective Date:	Part B Effective Date:
* "Split" is Medicare and no-Medicare		Do you have Medicare due to ESRD? ☐Y ☐N	Medicare due to ESRD? ☐Y ☐N

3 DENTAL

☐ ENROLL ☐ STANDARD
☐ WAIVE ☐ ENHANCED

☐ Retiree
☐ Retiree +1 Dependent
☐ Retiree +2 or more dependents

4 OPTIONAL VISION

☐ ENROLL
☐ WAIVE

☐ Retiree
☐ Retiree +1 Dependent
☐ Retiree +2 or more dependents

5 SELF/FAMILY ELECTIONS

Retiree ☐M ☐F	SSN	DOB	Dr Name		Provider ID Number	Existing Patient? ☐Y ☐N
SPOUSE ☐M ☐F	Last Name	First Name	M.I.	Dr	Provider ID Number	Medical ☐Y ☐N; Dental ☐Y ☐N; Vision ☐Y ☐N
	SSN	Date of Birth		Existing Patient? ☐Y ☐N		☐HMO ☐HDHP ☐UHC HMO ☐UHC NPPO ☐KP Gold ☐KP Silver
Ch1 ☐M ☐F	Last Name	First Name	M.I.	Dr	Provider ID Number	Enroll Medical ☐Y ☐N; Enroll Dental ☐Y ☐N; Enroll Vision ☐Y ☐N
	SSN	Date of Birth	Disabled? ☐Y ☐N	Existing Patient? ☐Y ☐N		
Ch2 ☐M ☐F	Last Name	First Name	M.I.	Dr	Provider ID Number	Enroll Medical ☐Y ☐N; Enroll Dental ☐Y ☐N; Enroll Vision ☐Y ☐N
	SSN	Date of Birth	Disabled? ☐Y ☐N	Existing Patient? ☐Y ☐N		

FORM NOT VALID UNLESS SIGNED BY RETIREE --------SIGN AUTHORIZATION ON BACK →

If you are waiving coverage, initial the Waiver of Coverage section, then sign below at "X". If you are enrolling in a new plan or making a change to your current coverage, initial the arbitration agreement next to the plan you are enrolling in, then sign and date below at "X".

WAIVER OF COVERAGE-I authorize the County of Sacramento to terminate my current County sponsored medical, dental and/or vision coverage as of Midnight December 31, 2020. I understand that re-enrollment shall be contingent upon the Annuitant meeting the eligibility requirements as stated in the Retiree Health Insurance Program Administrative Policy. ___________________ **(initial, also sign at "X" below)**

BINDING ARBITRATION-Health plan carriers_handle and resolve member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes the Plans use binding arbitration as the final method for resolving all such disputes. As a condition of your membership in the Plan, you must initial next to your plan carrier to indicate that you understand and agree to the following:

WESTERN HEALTH ADVANTAGE (WHA) and SUTTER HEALTH PLUS (SHP)

A. On behalf of myself and my eligible Dependents, I hereby apply for health care coverage offered through my Employer, and agree to be bound by the Group Service Agreement and Evidence of Coverage and Disclosure Form for the plan selected, 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 the Plan, 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.

WESTERN HEALTH ADVANTAGE--Retiree Initials: _____________ **(also sign at "X" below)** **SUTTER HEALTH PLUS--Retiree Initials:** _________________ **(also sign at "X" below)**

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.

Retiree Signature: **Date:** **(also sign below)**

AUTHORIZATION-All information on this form is true and correct; I understand 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 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. If applicable, I authorize the County to deduct from my pension the required premiums.

X RETIREE SIGNATURE____ Date_________________________________

OFFICE USE ONLY	MEDICARE SPLIT?	Effective Date Of Change	Group Number	Accepted By--Benefits Staff Representative:	Date
	☐Y ☐N	**01/01/2021**			