Employee Benefits Enrollment/Change Form

(800) 736-2292 ~ PO Box 619082 Roseville CA 95661 ~ Fax to **(916) 786-0906** or click **Secure Email** at www.acwajpia.com

Employer: _____

Effective Date: _____ Qualifying Event Date: _____ SSN: _____
(Date of Hire, Term, Marriage, etc.)

Reason for **ENROLLMENT** in coverage:	Reason for coverage **TERMINATION**:	Reason for **CHANGE**:	**Marital Status:**
☐ New Hire	☐ Employment Termination	☐ Active to Retired	☐ Single
☐ Marriage/Reg. Domestic Partnership	☐ Divorce	☐ Retired, New Medicare Enrollment	☐ Married
☐ Birth/Adoption/Legal Guardianship	☐ Overage Dependent	☐ Address Change	☐ Registered Domestic Partner
☐ Loss of Other Group Coverage	☐ Enrolled in Other Group Coverage	☐ Name Change	☐ Legally Separated
☐ Surviving Spouse Benefits[1]	☐ Death	☐ Open Enrollment[2]	☐ Divorced
☐ Open Enrollment *(COBRA Elections – use COBRA form)*	☐ Open Enrollment	☐ Other: _____ _____	☐ Widowed Date of Marital Status: _____

[1] Only available if provided by employer policy. [2] Changing Plans, but same dependents unless otherwise indicated below.

Enrollee Name: _____ Date of Hire: _____ Date of Birth: _____
LAST FIRST MI

Mailing Address: _____ Email: _____

Phone #: (_____) _____ Status (circle one): Active / Retired / Director Management (circle): Yes / No Union (circle): Yes / No

MEDICAL PLANS: Not all plans offered by all agencies. Please consult with your HR team to confirm plan availability.

Notes regarding this enrollment change (if any):

Enroll	Term	Relation-ship	Last	First	MI	SSN (required)	Gender	Date of Birth	Disabled Child	Anthem HMO enrollees, indicate Primary Care Physician ID# from Anthem .com (OB/Peds OK)	Anthem Classic PPO	Anthem Advantage PPO	Anthem Cal-Care HMO	Anthem CDHP	Anthem Value HMO	Kaiser HMO	Kaiser HMO / Optical	Kaiser CDHP	Kaiser Value HMO	Kaiser Sr. Advantage	UHC Medicare Advantage
		Member				See above															
		Spouse/ RDP																			
		Child																			
		Child																			
		Child																			
		Child																			

ANCILLARY PLANS: Not all plans offered by all agencies. Please consult with your HR team to confirm plan availability.

Notes regarding this enrollment change (if any):																
Enroll	Term	Relation-ship	Last	First	MI	SSN (required)	Gender	Date of Birth	Disabled Child	Delta Care HMO enrollees, indicate Network Facility Number	Delta Dental PPO	DeltaCare DHMO	Vision Service Plan	Life Insurance*	Emp. Assistance Prog.
		Member				See above									
		Spouse/ RDP													
		Child													
		Child													
		Child													
		Child													

Dependent verification documents, i.e. marriage/birth certificates, are required to enroll dependents. Documentation must be provided to substantiate mid-year changes. You must return this completed form and required documents to your employer within 31 days of the benefits effective date or the mid-year qualifying event date. Otherwise, you will have to wait until Open Enrollment to make benefit elections. Open Enrollment elections must be submitted during the annual Open Enrollment timeframe set by your employer.

***Separate enrollment form required for life insurance.**

All Plans

I agree to comply with the terms of the group contract. All of the information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied. Insurance fraud is a crime under California Penal Code 550. In the case deliberate fraud, my coverage may be retroactively terminated, resulting in my financial responsibility for claims and/or premiums paid by my employer. I have read and understand the provisions outlined on this form. I understand that at hire (or initial benefits eligibility), at Open Enrollment, and when experiencing a qualifying life event (such as birth, marriage or gain/loss of other coverage) I have the opportunity to make changes to my benefits enrollment. I must initiate a change within 31 days of the qualifying life event or wait until the following Open Enrollment. I cannot terminate my coverage mid-year without a qualifying life event justifying such a change in coverage.

Deduction Agreement: If applicable, I authorize my employer to deduct the required premiums from my wages.

Dental, Vision, Life and Employee Assistance Program: I agree to continue membership in the programs in which the employer covers all employees, or all employees and dependents, during employment and while the program is in force.

Anthem Blue Cross plans

Arbitration Agreement: I understand any dispute between myself (and/or any enrolled family member) and Anthem Blue Cross of California/CaliforniaCare Health Plans/WellPoint must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the Member and Anthem Blue Cross of California/CaliforniaCare Health Plans/WellPoint are giving up the right to have any dispute decided in a court of law before a jury.

Non-Participating Provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

Declining Coverage: If I am permitted to decline coverage for myself and/or my dependents, I will complete and attach a Health Declination Form and provide proof of other coverage.

Authorization to Obtain or Release Medical Information: Anthem Blue Cross is authorized to obtain and release information in compliance with the Insurance & Privacy Protection Act, Section 56.10 et. Sequence of the California Civil Code. I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Anthem Blue Cross of California all records pertaining to medical history, services rendered, or treatment given to anyone enrolled here under or added here after for purposes of review, investigation, or evaluation of an application, or evaluation of an

application or a claim. I also authorize Anthem Blue Cross of California and its affiliates, or its agents, designees, or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Master Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable Anthem Blue Cross of California and its affiliates to process claims. A copy of this authorization shall be as valid as the original.

California Kaiser Foundation Health Plan, Inc., 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.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

_____ _____

Signature required for enrollment in ALL Plans **Date**

Form revised: 1/6/2022