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

916.874.2020 **PHONE** 916.874.4621 **FAX** MyBenefits@Saccounty.net **EMAIL**
http://www.personnel.saccounty.net/Benefits/Pages/default.aspx **WEBSITE**

DATE STAMP AREA

SPECIAL DISTRICT OPEN ENROLLMENT FORM--**Return by 10/26/2018**

MEDICAL COVERAGE

☐SINGLE ☐FAMILY ☐WAIVE

☐ **KAISER PERMANENTE** ☐HMO
☐ **SUTTER HEALTH PLUS**
☐ **WESTERN HEALTH ADVANTAGE** ☐HIGH DEDUCTIBLE

DENTAL COVERAGE

☐SINGLE ☐FAMILY ☐WAIVE

OPTIONAL VISION

☐SINGLE ☐FAMILY ☐WAIVE

EMPLOYEE INFORMATION

DISTRICT NAME:

Last Name | First Name | M.I. | Birthdate | SSN

Physical Address | City | Zip | Phone | Email

Dr. Name | Provider ID # | Existing patient? ☐Y ☐N

FAMILY ELECTIONS Choose coverage for each family member

Spouse ☐M ☐F	Last Name / SSN	First Name / Date of Birth	M.I.	Dr / Existing Patient? ☐Y ☐N	Provider ID Number	Enroll Medical ☐Y ☐N	Enroll Dental ☐Y ☐N	Enroll Vision ☐Y ☐N
Ch1 ☐M ☐F	Last Name / SSN	First Name / Date of Birth	M.I. / Disabled? ☐Y ☐N	Dr / Existing Patient? ☐Y ☐N	Provider ID Number	Enroll Medical ☐Y ☐N	Enroll Dental ☐Y ☐N	Enroll Vision ☐Y ☐N
Ch2 ☐M ☐F	Last Name / SSN	First Name / Date of Birth	M.I. / Disabled? ☐Y ☐N	Dr / Existing Patient? ☐Y ☐N	Provider ID Number	Enroll Medical ☐Y ☐N	Enroll Dental ☐Y ☐N	Enroll Vision ☐Y ☐N
Ch3 ☐M ☐F	Last Name / SSN	First Name / Date of Birth	M.I. / Disabled? ☐Y ☐N	Dr / Existing Patient? ☐Y ☐N	Provider ID Number	Enroll Medical ☐Y ☐N	Enroll Dental ☐Y ☐N	Enroll Vision ☐Y ☐N

Indicate if any child over age 26 is disabled ☐Y ☐N | If yes, which child?

Documentation is required for dependents to validate their legal relationship to you. Failure to provide documentation will result in the dependent not being enrolled.

SIGN AUTHORIZATION ON BACK

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

WAIVER OF COVERAGE-I authorize the County of Sacramento to terminate my current County sponsored medical, dental and/or vision coverage. I understand that re-enrollment shall be contingent upon meeting the eligibility requirements as stated in the Summary of Benefits. Coverage and contributions shall end December 31st in accordance with Open Enrollment 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

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-- Initials: _____ (also sign at "X" below) **SUTTER HEALTH-- 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.

Employee 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 misstatements or omissions may result in future claims being denied and/or the policy being rescinded. My signature indicates I accept the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, coverage, and all associated policies. I authorize my employer to deduct applicable premiums from my pay.

X EMPLOYEE SIGNATURE_____ Date_____

OFFICE USE ONLY	Effective Date	Benefits Staff Reviewed	BenefitBridge?	Date
	01/01/2019			