



Universal Enrollment Form

Medical-Dental-Vision for Active Participants

Effective Date: _____, 20__

SECTION 1. Employee Information			
Name (Last, First, M.I.):	Social Security Number: - -	Date of Birth: / /	Hire Date: / /
Home Address (Number, Street, Apt#):		City, State, Zip Code:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	Home Phone Number: () -	Hours Worked Weekly:

SECTION 2. Qualifying Event - This Election is for:	
<input type="checkbox"/> New Enrollment - Event Date: _____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change in Enrollment - Event Date: _____ <input type="checkbox"/> Adding Dependent(s) - Event Date: _____ <input type="checkbox"/> Deleting Dependent(s) - Event Date: _____ <input type="checkbox"/> Address Change - Event Date: _____ <input type="checkbox"/> COBRA Continuation (Effective Date: _____)	<input type="checkbox"/> Name Change* - Event Date: _____ (*Please fill in New and Previous Name below) New Name: _____ Previous Name: _____ <input type="checkbox"/> Terminating Employment - Event Date: _____ <input type="checkbox"/> Other: _____ Event Date: _____

SECTION 3. COVERAGE ELECTION: Medical / Dental / Vision								
<input type="checkbox"/> Kaiser Permanente HMO Group #: 421-0002	<input type="checkbox"/> Blue Cross HMO Group #: 57984A	<input type="checkbox"/> Blue Cross PPO Group #: 1182VK	<input type="checkbox"/> VSP Vision Group #: 12262043/0004	<input type="checkbox"/> Delta Dental Group #: 7071-0030				
<u>MEDICAL</u> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse / Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage		<u>VISION</u> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse / Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage		<u>DENTAL</u> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse / Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family Coverage				
(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth & Age	Gender	Totally Disabled	If enrolling in Blue Cross HMO - Primary Care Provider ID # and Name.	Is this your Current Doctor?
	Self		- -	/ / Age:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID # Name	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		- -	/ / Age:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID # Name	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child 1		- -	/ / Age:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID # Name	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child 2		- -	/ / Age:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID # Name	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child 3		- -	/ / Age:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	ID # Name	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you included stepchildren as dependents? <input type="checkbox"/> NO <input type="checkbox"/> YES - If "yes" indicate name/s: _____ Do your stepchildren reside with you? <input type="checkbox"/> NO <input type="checkbox"/> YES Are they dependents upon you for support and maintenance? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)</i>								

SECTION 4. ADDITIONAL HEALTH INSURANCE INFORMATION			
Do you or your dependents have other medical coverage? <input type="checkbox"/> NO <input type="checkbox"/> YES - If yes, please complete this section.			
	Name	Name and address of other insurance Carrier	Effective Date
Self			
Spouse / Domestic Partner			
Child 1			
Child 2			
Child 3			

For Kaiser Permanente Participants Only:
Are you now or have you ever been a Kaiser Permanente member? <input type="checkbox"/> No <input type="checkbox"/> Yes*
*If "Yes", please list your Kaiser Permanente Medical Record Number: _____

Prior Coverage for PPO (Prudent Buyer and BlueCard) Plans Only

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name	Plan Start Date	Plan End Date	Carrier Name	Reason for Ending Coverage
Self		/ /	/ /		
Spouse / Domestic Partner		/ /	/ /		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /	/ /		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter		/ /	/ /		

Existing Dental Insurance

Do you your Spouse / Domestic Partner currently have a dental plan? No Yes - If Yes, who is covered:
 Yourself Spouse / Domestic Partner Dependent children

If Delta Dental, indicate Group Number: _____

SECTION 5. Medicare Section

Are you retired?..... <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).
If yes..... Part A <input type="checkbox"/> No <input type="checkbox"/> Yes	
..... Part B <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do any of your dependents have Medicare?..... <input type="checkbox"/> No <input type="checkbox"/> Yes	HIB # _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____
If yes for your dependents..... Part A <input type="checkbox"/> No <input type="checkbox"/> Yes	
..... Part B <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name(s) of Medicare Dependent(s) _____ _____	HIB # _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____

SECTION 6. Certification of Students Over Age 20

I hereby certify that my dependent(s) is/are currently enrolled as a full time student(s) at the school(s) listed below:

Name: _____ # of Hours: _____	Name: _____ # of Hours: _____
School: _____ State: _____ # of Units: _____	School: _____ State: _____ # of Units: _____

SECTION 7. Declination of Coverage (Complete this section ONLY if declining coverage for yourself OR eligible dependents)

<input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Child(ren)	DECLINE (check all that apply AND give reason in right column)	REASON <input type="checkbox"/> Have Other Group Coverage. Name of Insurance: _____ <input type="checkbox"/> Have Other Individual Coverage. Name of Insurance: _____ <input type="checkbox"/> Other (Explain): _____
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Insurance Plan(s) you are choosing to waive (Check all that apply): Medical Dental Vision

I hereby elect to decline enrollment for coverage under the CLPCCD insurance plan(s) checked above for the coming year. I understand that I will not be eligible for any insurance I do not elect at this time during the coming policy year and that this election will remain in effect until the next annual open enrollment period.

Employee's Signature for DECLINATION of Coverage: _____ Date: _____

Payroll Deduction Contributions
 The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and that the amount may change in the future.

Kaiser Permanente Arbitration Agreement
 I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs 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, 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 my 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.

Blue Cross
Non-Participating Provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. **HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance. **Effective Date:** The effective date of coverage is subject to Blue Cross-of California approval.
Arbitration Agreement: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions: I understand that any and all disputes between myself (and/or any enrolled family member) and Blue Cross of California/ BC Life & Health, including claims for medical malpractice, 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 Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/ Certificate.
 If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.
 I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Delta Dental
 I understand I may be required by the employer to pay for COBRA benefits.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis. This signature also verifies the accuracy of the information on this form.

I have read, understand, and agree to the terms and conditions above.

Signature of Employee: _____ Date: _____