



**Human Resources
Employee Benefits and Services**

For Office Use Only		
Effective Month Date	Day	Year
KP Group ID #	KP Sub EU #	KP Dep EU #
Blue Shield Group #		
Blue Shield Plan ID #	Blue Shield Class ID #	
Emp ID #		

**Retiree Medical Plan Enrollment/Change Form
County of San Bernardino—Retirees**

A. New Retiree Open Enrollment Change in Status

B. CHOOSE A MEDICAL PLAN AND A HIGH OR LOW OPTION

<input type="checkbox"/> Kaiser Permanente Traditional HMO Plan	<input type="checkbox"/> Blue Shield Signature HMO	Option: <input type="checkbox"/> High Option <input type="checkbox"/> Low Option For PPO Only: <input type="checkbox"/> California <input type="checkbox"/> Out of State
<input type="checkbox"/> Kaiser Medicare Advantage *	<input type="checkbox"/> Blue Shield PPO	
<input type="checkbox"/> Kaiser Permanente Medicare COB	<input type="checkbox"/> Blue Shield PPO COB	
	<input type="checkbox"/> Blue Shield 65 Plus (HMO) *	

***Medicare integrated plan. Please complete both the County and the Medicare enrollment forms.**

Previous Medical Plan: _____

C. RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVOR INFORMATION

Social Security Number	Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Month Day Year	Date of Retirement Month Day Year	Check One <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
Last Name	First Name	MI	For Name Change, List Former Name Here	
Mailing Address <input type="checkbox"/> Check Here If New Address		Home Phone ()		Email Address
City		State	Zip Code	Blue Shield Signature HMO and 65 Plus HMO Primary Care Physician ID No./Group ID No. Previously Visited? <input type="checkbox"/> Yes <input type="checkbox"/> No
Residential Address (if different from mailing address)				

D. NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME, LIST ALL DEPENDENTS TO BE COVERED

						Blue Shield HMO & 65 Plus HMO Enrollees Only	
Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
Spouse/Domestic Partner:		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual open enrollment period.

E. ENROLLMENT CHANGES ONLY IF YOU ARE ADDING OR DROPPING DEPENDENTS, LIST DEPENDENTS AND INDICATE EFFECTIVE DATE: Month Day Year

						Blue Shield HMO & 65 Plus HMO Enrollees Only	
Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Spouse/Domestic Partner (See Section F):	<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Children:	<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

F. IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE OR DOMESTIC PARTNERSHIP. IF REMOVING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH

	Month Day Year	<input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Dissolution
		<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death

**PLEASE READ THE FOLLOWING DISCLOSURES AND SIGN YOUR AGREEMENT ON THE LAST PAGE OF THIS FORM
NOTE: KAISER MEMBERS ALSO NEED TO SIGN THE KAISER ARBITRATION AGREEMENT (SECTION I) ON THE FOLLOWING PAGE**

- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
- Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

L. DISABLED DEPENDENTS

Please list the names of any disabled dependents you are enrolling in the space below:

M. QUALIFIED CHANGE IN STATUS EVENT

I understand that I may elect to add or delete eligible dependents to my medical plan if a "Qualifying Change in Status Event" occurs. Qualifying events are:

- Marriage, domestic partnership, divorce or dissolution of domestic partnership of the member
- Birth or adoption of a child by the member
- Death
- Termination or commencement of a spouse's or domestic partner's employment
- Over age dependent
- A significant change in the medical coverage of the member or dependents attributable to the spouse's or domestic partner's employment, such as offering insurance for the first time or a significant increase or decrease in premium cost
- Medicare entitlement

To add or delete dependents, I understand that I must submit a new Medical Plan Enrollment/Change Form within sixty (60) days of a Qualifying Change in Status Event. If I do not submit a Medical Plan Enrollment/Change Form within sixty (60) days, my request may be denied. All requests must be consistent with the stated qualifying event.

N. SELECTION OF A LOW OPTION HEALTH PLAN

I hereby acknowledge that I understand the following in connection with the County of San Bernardino's Low Option Health Plan (Low Option) through either Kaiser Permanente or Blue Shield of California or any subsequent health plan provider(s):

- My decision to participate in the Low Option Plan is completely voluntary and is made with full understanding of the risks and potential additional expenses including applicable deductibles and increases in co-payments or co-insurances.
- I understand that by selecting the Low Option Plan my out-of-pocket expenses for medical care will increase.
- The County and the health plans have provided me with access to education and communications on the Low Option Plan.

I hereby release the County of San Bernardino and the Board of Supervisors from any fiduciary (or other) liability and responsibility for any losses incurred or other adverse consequences experienced in connection with my Low Option decisions.

O. AGREEMENT

I hereby elect the medical plan as designated on this enrollment form. I have also listed eligible dependents added to the medical plan, or to be deleted from the plan.

I authorize the County of San Bernardino to deduct from my salary or monthly retirement benefit payment the amount required to cover my share of the payment (including any future premium increases).

I agree for myself and my dependents, effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the Group Agreement as it may be amended
- To obtain all medical services from providers associated with the medical plan, unless the plan specifically provides otherwise
- To authorize providers who have rendered services to me and my dependents to make medical information and records regarding those services available to the medical plan and their providers who, in turn, may share such records among themselves. This information may also be released to appropriate government agencies
- To complete and submit consents, releases assignments and other documents related to protecting the medical plan's rights under the Group Agreement. This includes coordinating benefits with other group medical plans, insurance policies or Medicare. I also agree to pay the cost incurred by the medical plan out of any awards, settlements or payments made to me in connection with personal injuries sustained by me or my dependents, and

I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to my health insurance carrier for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement and disease or care management programs. The health insurance carrier's Notice of Privacy Practices is included in their evidence of coverage or certificate of insurance for coverage. A copy of this notice can be obtained by calling the health insurance carrier's member services.

I certify that, to the best of my knowledge, all information furnished by me here is true and correct. I certify that the names of the persons listed in Section H are enrolled in Parts A & B of Medicare.

I also certify that I accept the above terms of the plan to which I subscribe.

Subscriber's Signature _____ **Date** _____