City of Bakersfield - Health Benefits Enrollment / Change Form COBRA 2016

It is your responsibility to complete the proper sections of this form & submit the documentation in a timely manner. Incomplete/unsigned forms will be rejected. If you need assistance please contact the Human Resources Office at 661-326-3774. 1600 Truxtun Ave, Bakersfield CA 93301

Mark all boxes that apply

☐ Employee - Hire Date:_____
☐ Retiree
☐ Loss of Other Group Coverage – (Documents Required)
☐ Name Change – Previous Name

Open Enrollment - ONLY

☐ Changing Medical Plan
From: _____

☐ Changing Dental Plan
From:_____

Mark all boxes that apply

ADD: Newly Acquired / Eligible Dependent(s) due to:

☐ Marriage (Marriage or Ceremony Cert. req'd - within 30 days)
☐ New Domestic Partnership (Documents Required)
☐ Loss of Other Group Coverage (Proof of loss)
☐ Birth of child (Hospital or Birth Certificate Required)
(Must be added within 30 days of birth or at Open Enrollment)
☐ Adoption/Legal Guardianship (Documents Required)

Event Date: _____

DELETE: Dropping Dependent(s) due to:

☐ Divorce (Documents Required)
☐ Over-age Dependent
☐ Termination of Domestic Partnership
☐ Other: Reason:

OFFICE USE ONLY

Effective Date
Blue Shield PPO-
Blue Shield HMO Access+-
Blue Shield HMO TRIO-
Kaiser 132733-
MES 162
Met Life 142451-000-
PUD 711874-000-
Imperial - _____
Napa - _____

I am electing to **WAIVE....** ☐ my **MEDICAL (prescription drugs, mental health, vision included) -** ☐ **DENTAL coverage.**
You must also complete the WAIVER OF HEALTH BENEFITS ACKNOWLEDGEMENT see Waiver form in Section 9

SECTION 1 MEDICAL & DENTAL PLAN CHOICE

MEDICAL PLANS (Includes Prescription Drug, Mental Health, Vision) Select one

☐ **Blue Shield PPO & VPPO** You must sign, see Sections 4 and 5

☐ **Blue Shield HMO Access+ (Broad Network) & VHMO** You must sign, see Sections 4 and 5

You must select a Medical Group (MG) Name **&** Primary Care Physician (PCP) name

The IPA may be one of the following: Bakersfield Family Medical Group (BFMC), Gemcare (GC) or Independence Medical Group (IMG)

☐ **Blue Shield HMO TRIO (Gemcare Network Only) & VHMO ** You must select a primary care physician only ****
You must sign, Sections 4 and 5

☐ **Kaiser Permanente HMO & VHMO** You must sign, Sections 4 and 6

☐ **Kaiser Permanente DEDUCTIBLE HMO & VHMO** You must sign, Sections 4 and 6

DENTAL PLANS Select one

☐ **Met Life Preferred Dental Program** You must sign, Sections 4 and 7

☐ **Pacific Union Dental - Imperial Plan** You must sign, Sections 4 and 8

☐ **Pacific Union Dental - Napa Plan** You must sign, Sections 4 and 8

SECTION 2 Personal Information (This section MUST be completed for all transactions)

Employee - Last Name First & Middle Initial	Social Security #	Birth mm/dd/yy	Blue Shield HMO Only: PCP Name	Existing Member	MG Name (BFMC, GC, IMG)

Street Address City, State, Zip		
	☐	

Phone # Work #	**Marital Status:** ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow(er)	Gender: ☐ Male ☐ Female

SECTION 3 Eligible Dependents - Your legal spouse, your children under the age of 26. Children who are ages 19-23 must be in school to be covered by your dental & vision plan. Children over 23 are not eligible for your dental or vision plan. Student status & birth certificates may be requested. Please notify Benefits if your child is between 19-23 and is a Full-Time Student.

Last Name, First, Middle Initial	M/F	Relationship	Social Security #	Birth mm/dd/yy	PCP Name	Existing Member	MG Name
		SPOUSE				☐	
						☐	
						☐	
						☐	

SECTION 4 Employee Authorization and Signature

I declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements. I understand that I am responsible for the tax consequences (including interest & penalties) should the IRS or the City of Bakersfield determine that the benefits requested in this document have a tax consequence. I also certify that the information provided on this form is complete, true & correct to the best of my knowledge. DEDUCTION AUTHORIZATION: I authorize the City of Bakersfield to deduct from my wages the required dues.

Employee / Applicant Signature Required → Date:

SECTION 5 Blue Shield PPO and Blue Shield Access+ and Trio HMO Plan Agreements

Disclosure of Personal and Health Information: Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.

Blue Shield Authorization: I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of coverage, my coverage may be canceled, or, following notice, rescinded.

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

Employee / Applicant Signature Required → Date:

SECTION 6 Kaiser Permanente HMO Plan Agreement

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 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 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 / Applicant Signature Required → Date:

SECTION 7 Met Life Preferred Dental Program Agreement

I attest by signing below that I have reviewed the information provided in this application & to the best of my knowledge & belief; it is true & accurate with no omissions or misstatements. NON-PARTICIPATING DENTAL PROVIDER: I understand that I am responsible for a greater portion of my dental costs when I use a non-participating dental provider.

Employee / Applicant Signature Required → Date:

SECTION 8 Pacific Union Dental Agreement

I agree, that if I or my dependents seek services when not eligible for coverage, that I will be required to pay the dentists usual fee. Dental Release: I, on my behalf & on the behalf of my Family Members listed on this form hereby authorize the Plan to release dental information to official government agencies when required under appropriate Federal & State Legislation & regulation or pursuant to legal process & to release & obtain dental information to or from other appropriate agencies/providers for the providing of necessary health care services and/or administrative services under the plan.

Employee / Applicant Signature Required → Date:

SECTION 9 SIGNATURE

You may email, scan or fax this completed form to Human Resources, AdmHRS@bakersfieldcity.us or fax 661-852-2070 or mail to 1600 Truxtun Ave, Bakersfield CA 93301. For questions please call 661-326-3774