



SECTION 4 Employee Authorization and Agreement

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.

SECTION 5 Anthem Blue Cross PPO/Prudent Buyer Plan & Anthem Blue Cross HMO Plan Authorization & 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 misstatement. DEDUCTION AUTHORIZATION: I authorize my employer to deduct from my wages the required dues. 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 Anthem Blue Cross approval. REQUIRED FOR BINDING ARBITRATION: The following provision does not apply to class actions: IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTION LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any disputes as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, 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 arbitration." THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.

SECTION 6 Kaiser Permanente HMO Plan Authorization & Agreement

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subjected 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, 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*.

SECTION 7 Met Life Preferred Dental Program Authorization & 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.

SECTION 8 Pacific Union Dental Authorization & 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.

SECTION 9 ELECTRONIC SIGNATURE

Read the electronic signature agreement and then if you agree, check the box before the statement.

I confirm that I have reviewed, understand, meet and agree to the above terms and conditions of the medical and/or dental plans that I have selected.

PRINT YOUR NAME _____

Date _____

You may email, scan or fax this completed form to Ginger Rubin Benefits Technician, grubin@bakersfieldcity.us or fax 661.852.2070 or mail to 1600 Truxtun Ave RM 101, Bakersfield CA 93301. For questions please call 661.326.3094.