UNIVERSAL BENEFITS ENROLLMENT OR CHANGE WORKSHEET

City of Santa Rosa

Event/ Hire Date: ____________ **Effective Date: ___________**

Reason for changing benefits (circle all that apply):

New Hire / Add Dependent / Delete Dependent / Open Enrollment / Retirement / Other Please explain:

EMPLOYEE INFORMATION – COMPLETE IN FULL

Employee Name (Last, First, Middle Initial)	Gender: M / F	Employee Type:	Social Security No.

Employee Street Address	City, State	Zip Code
Employee Mailing Address (if different)	**City, State**	**Zip Code**
Job Title:	**Department:**	**Unit:**

Marital Status (circle one): Single Married State Domestic Partner Legally Separated Divorced

LIST ALL DEPENDENTS TO BE ENROLLED IN COVERAGE (All eligible dependent children under 26 years of age may be enrolled in medical, dental and vision coverage)

Last Name, First Name, M.	Gender	Birth Date	Social Security No.	Relationship (circle one):	Coverage / Action	
	M / F			Self	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Spouse / Domestic Partner	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change

MEDICAL ELECTION (MISCELLANEOUS EMPLOYEES ONLY) - PLEASE CHECK ONLY ONE APPLICABLE BOX(ES)	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY	WAIVE
Health Plan: City EPO				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)
Health Plan: City PPO				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)
Health Plan: Kaiser Permanente Traditional HMO Plan: Active (GP# 8961-0000) Retiree (GP# 8961- 0002)				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)

DENTAL & VISION ELECTIONS - PLEASE CHECK APPLICABLE BOX(ES)	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY	WAIVE
Dental & Vision - All Units EXCEPT UNIT 8 (Dental = Delta Dental PPO Group #3066-0015 / Vision = VSP)				
Dental & Vision - UNIT 8 CORE ONLY (Dental = Delta Dental PPO Group #3066-01001 / Vision = VSP)				
Dental & Vision - UNIT 8 CORE & BUY-UP OPTION (Dental = Delta Dental PPO Group #3066-01002 / Vision = VSP)				

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ENROLLMENT DECLINATIONS	ADDITIONAL HEALTH/DENTAL COVERAGE
Coverage is declined for the following people: **Self OR Spouse Only OR Spouse & Child(ren) OR Child(ren) only because:** **the individuals are insured by:** **Insurance Carrier:** _____: **OR Other reasons:**_____ _____	**Secondary/primary health and/or dental coverage exists for:** **Self Spouse Only Spouse &Child(ren) Child(ren) only** **Health Carrier:**_____ **Policy #/Effective Date:** _____ **Dental Carrier:** _____ **Policy #/Effective Date:**_____

Authorization to Obtain OR Release Medical Information Explanation: The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the ***Confidentiality of Medical Information Act*** , effective January 1, 1980, Section 56 et. Seq., of the ***California Civil Code*** . Your cooperation is being requested.
Authorization to Obtain OR Release Medical Information: I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim. **Initial**_____

Arbitration Agreement: I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and 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 claims subject to ***ERISA*** , or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.
Initial if you have selected the City EPO or the City PPO_____

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.*

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Signature Required for Kaiser Permanente Plan **Date**

(All Plans-EPO, PPO, Kaiser Permanente) X	Signature of witness (only required if employee signature is "X")	Date:

HUMAN RESOURCES USE ONLY				OLD LEVEL (circle one)		
Medical Plan Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY
Dental Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY
Vision Plan Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY

Office Use Only **Confirmation Sent to PY:** _____ **Received HR** _____ **By:** **on:**	**Entered EBS**_____ **By:** _____	**COPY Received PY** _____ **By:**