

UNIVERSAL BENEFITS ENROLLMENT OR CHANGE WORKSHEET



Event/ Hire Date: _____

Effective Date: _____

Reason for changing benefits (check 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)	Male Female	Employee Type:	Phone No.
Employee Street Address (street, city, state, zip)			
Employee Mailing Address (if different)			
Job Title:	Department:		Unit:

Marital Status (check 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 (check one):	Coverage / Action	
					Medical	Dental & Vision
	Male Female			Self	Add Delete No Change	Add Delete No Change
	Male Female			Spouse Domestic Partner	Add Delete No Change	Add Delete No Change
	Male Female			Natural Child Step Child Legal Child Domestic Partner Child	Add Delete No Change	Add Delete No Change
	Male Female			Natural Child Step Child Legal Child Domestic Partner Child	Add Delete No Change	Add Delete No Change
	Male Female			Natural Child Step Child Legal Child Domestic Partner Child	Add Delete No Change	Add Delete No Change
	Male Female			Natural Child Step Child Legal Child Domestic Partner Child	Add Delete No Change	Add Delete No Change

MEDICAL ELECTION (MISCELLANEOUS EMPLOYEES ONLY) PLEASE CHECK ONLY ONE APPLICABLE BOX(ES)	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY	WAIVE
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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 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
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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)				

Teamsters Employees - Please also fill out Teamster Enrollment Form [HERE](#)

Safety Employees - Please also fill out PERS Enrollment Form [HERE](#)

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

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*.

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:
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HUMAN RESOURCES USE ONLY			OLD LEVEL (check 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

<p>Office Use Only</p> <p>Confirmation Sent to PY:</p> <p>_____ Received HR</p> <p>By: _____ on: _____</p>	<p>entered EBS _____ By: _____</p>	<p>COPY Received PY _____</p> <p>By: _____</p>
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