Tulare County 2024 Health Plan Enrollment Form
ACTIVE EMPLOYEES

Select One: ☐ **New Hire** ☐ **Mid-Year Change** ☐ **Open Enrollment** Effective Date: _____

Last Name:	First Name:	MI:	Employee ID#:	Social Security #:

Mailing Address:	City:	State:	Zip Code:	Phone Number:	Date of Birth:	Gender:

Complete this Section for Mid-year Change: **Must submit to HR&D-Benefits within 30 days of the event date**

Qualifying Status Change:

- ☐ Marriage
- ☐ Divorce/Legal Separation
- ☐ Birth
- ☐ Adoption
- ☐ Dependent Loss of Eligibility
- ☐ Employment Status Change
  - ☐ Spouse ☐ Self
  - Specify:_____
  - _____
- ☐ Medicare
- ☐ Moved Out of Service Area
- ☐ Military Duty/Deployed
- ☐ Leave of Absence*
- ☐ Return to Work
- ☐ Death _____
- ☐ Other _____

Requested Change:

- ☐ New Enrollment
- ☐ Add Dependent(s)
- ☐ Remove Dependent(s)
- ☐ Suspend Coverage*
- ☐ Reinstate Coverage
- ☐ Cancel Coverage
- ☐ Waive Coverage

Event Date: _____/_____/_____

- Effective date of coverage to enroll, reinstate, or add coverage due to mid-year event is the first day of month following the event date or date of receipt; whichever is later.
- Effective date of coverage to terminate, remove, suspend, or cancel coverage is the last day of the month following the event date or date of receipt; whichever is later.
- Effective date to add a child due to birth is the first day of the month following the date of the birth.

ALL CHANGE REQUESTS ARE SUBJECT TO ELIGIBILITY REVIEW

Health Plan Options – *Make a selection from each section (A, B, C & D)*

A. Coverage Level: ☐ **Employee Only** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**

B. Members Enrolling: ☐ **Myself** ☐ **Legal Spouse** ☐ **Registered Domestic Partner** ☐ **Child(ren)** ☐ **Other**

C. Medical Plans *(Select One)*

- ☐ 1. Anthem Blue Cross $0 Deductible PPO Plan
- ☐ 2. Anthem Blue Cross $500 Deductible PPO Plan
- ☐ 3. Anthem Blue Cross $750 Deductible PPO Plan
- ☐ 4. Anthem Blue Cross $2500 High Deductible PPO Plan ☐ **Health Savings Account** **$**
- ☐ 5. Kaiser Permanente HMO Deductible Plan
- ☐ 6. Kaiser Permanente HMO Traditional Plan

D. Dental Plans *(Select One)*

- ☐ 1. Delta Dental PPO
- ☐ 2. DeltaCare USA HMO

Are you now or have you ever been a Kaiser Permanente member?
☐ NO ☐ YES - Kaiser Permanente Medical Record #_____
Kaiser Group #:_____ Kaiser Enrollment Unit #:_____

Dependent(s) Name:	Relationship:	Date of Birth:	Social Security #:	Gender:	Add	Remove
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐

☐ ***I understand that I will be required to provide documentation that verifies the relationship of any dependent(s) I enroll on the plan***

MEDICARE: Do you or any of your dependents have Medicare? ☐ **NO** ☐ **YES - If yes, please provide a copy of your Medicare Card(s).**

YOU: ☐ PART A ☐ PART B ☐ BOTH Effective Date:_____ Eligibility Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

DEPENDENT: ☐ PART A ☐ PART B ☐ BOTH Effective Date:_____ Eligibility Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

***LEAVE OF ABSENCE – SUSPEND COVERAGE:**

☐ I acknowledge that my employer has explained the coverage available to me during my Leave of Absence and that I have every right to remain enrolled in this coverage and I have decided to SUSPEND my coverage. _____ *Initial*

☐ I understand that upon my return-to-work I must submit a Change Request Form to reinstate my coverage or my coverage will remain suspended, and I will forfeit my benefit amount for the remainder of the plan year. _____ *Initial*

For Office Use Only: *Employee ID#* _____ *BU*_____ *Event Date:* _____ *Coverage Eff Date:* _____

☐ *Approved* _____ ☐ *Supporting Docs Rcvd:*_____ *PR Ded / Ben Amt Date:* _____

☐ *Denied* _____ *Reason*_____

Keyed Date: _____ *By*_____*Comments:*_____

REQUIRED SIGNATURES ON REVERSE PAGE

PARTICIPANT SIGNATURE REQUIRED

I understand that as a participant in the TULARE COUNTY Flexible Benefit Plan, my plan selections are effective on the eligible date of enrollment through December 31, 2024, and **cannot** be changed until Open Enrollment. Dependents can only be removed or added from the plan during open enrollment or upon a qualifying change in family status as defined by the IRS regulations and the COUNTY OF TULARE Flexible Benefit Plan. A change in status means, but not limited to, marriage, divorce, legal separation, birth, adoption of a child, employment change, or death. Qualifying status changes **must be reported within 30 days of the event and accompanied by the appropriate documentation**. I also understand that any contribution I am required to make for my benefit selections will be taken from my earnings prior to the deduction of payroll taxes as allowed by State and Federal laws.

I have read and understand the binding arbitration and plan disclosure information printed on this form. I understand my acceptance of these provisions is a requirement to enroll in the health plan. My signature below indicates that I understand and agree to the terms and conditions required by the insurance carriers and that all the information that I provided on this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan and that any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.

Participant Signature: _____ Date: _____

DISCLOSURE INFORMATION

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

ANTHEM BLUE CROSS BINDING ARBITRATION AGREEMENT

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. 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 dispute 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.* YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (required): _____ Date: _____