Tulare County 2024 Health Plan Enrollment Form
RETIREES

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

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

Address:	Phone Number:	Date of Birth:	Gender:

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

Qualifying Status Change:		Requested Change:	Event Date: _____/_____/_____
☐ Marriage ☐ Divorce/Legal Separation ☐ Birth ☐ Adoption ☐ Employment Status Change ☐ Spouse ☐ Self Specify:_____ _____	☐ Dependent Loss of Eligibility ☐ Medicare ☐ Moved Out of Service Area ☐ Death _____ ☐ Other _____	☐ New Enrollment ☐ Add Dependent(s) ☐ Delete Dependent(s) ☐ Cancel Coverage*	– Effective date of 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 or cancel coverage is the last day of the month following the event date or date of receipt; whichever is later. **ALL CHANGE REQUESTS ARE SUBJECT TO ELIGIBILITY REVIEW**

Health Plan Options

A. Medical Plans (Select One)

UNDER 65 (Includes Medical, Dental & Vision)	OVER 65 (Medical Only)
☐ 2. Anthem Blue Cross $0 Deductible PPO Plan	☐ 2. Anthem Blue Cross $0 Deductible PPO Plan
☐ 3. Anthem Blue Cross $500 Deductible PPO Plan	☐ 3. Anthem Blue Cross $500 Deductible PPO Plan
☐ 4. Anthem Blue Cross $750 Deductible PPO Plan	☐ 4. Anthem Blue Cross $750 Deductible PPO Plan
☐ 5. Anthem Blue Cross $2500 High Deductible PPO Plan	☐ 5. Anthem Blue Cross $2500 High Deductible PPO Plan
☐ 6. Kaiser Permanente HMO Deductible Plan	☐ 6. Kaiser Permanente Senior Advantage Plan
☐ 7. Kaiser Permanente HMO Traditional Plan	

B. Dental Plans (Select One)

☐ 1. Delta Dental PPO

☐ 2. DeltaCare USA HMO

Group #_____

Enrollment Unit #_____

Are you now or have you ever been a Kaiser Permanente member: ☐ NO ☐ YES

Kaiser Medical Record # _____

Please check all those you are enrolling:
- ☐ Myself
- ☐ Legal Spouse
- ☐ Registered Domestic Partner
- ☐ Child(ren)

Check Coverage Level:
- ☐ Retiree Only
- ☐ Retiree + Spouse
- ☐ Retiree + Child(ren)
- ☐ Retiree + Family

***Cancelling Coverage:**
- ☐ Myself
- ☐ Legal Spouse
- ☐ Registered Domestic Partner
- ☐ Child(ren)

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

Dependent(s) Name:	Relationship:	Date of Birth:	Social Security #:	Gender:
1				
2				
3				

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:_____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

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

Anthem BC PPO – Deductible & Office Visit Co-Pays are waived when you use a Medicare Assigned Provider
Kaiser HMO – When you turn 65, you MUST enroll in Medicare and Kaiser Senior Advantage Plan

*** CANCELLING COVERAGE: I understand that if I cancel my coverage as a primary subscriber in the Tulare County Retiree Health Insurance Program that I likely will not be eligible to enroll again. Please give a brief explanation why you are canceling coverage:**

_____

For Office Use Only:

Retiree ID# _____ ***Retirement Date:*** _____ ***Coverage Eff Date:*** _____ ***Pension Ded Date:*** _____ ***Direct Pay*** _____

Keyed A/D 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: _____