



**RETIRED EMPLOYEE  
HEALTH PLAN ELECTION/CHANGE FORM**

**EMPLOYEE BENEFITS OFFICE**

700 H Street, Room 6750, Sacramento, CA 95814

**A-G (916) 874-5569**

**H-O (916) 874-5582**

**P-Z (916) 874-5568**

**Fax (916) 874-4621**

**Office Use Only**

Effective Date \_\_\_\_\_

Group Number \_\_\_\_\_

Rate Change  Yes  No Date \_\_\_\_\_

Certs \_\_\_\_\_ Verified \_\_\_\_\_

<p align="center"><b>Kaiser Permanente (Initial Required on Part VII)</b></p> <input type="checkbox"/> HMO <input type="checkbox"/> HDHP HMO <input type="checkbox"/> Senior Advantage (Form Required) <input type="checkbox"/> Out of Area (KPMP) (Form Required)	<p align="center"><b>Health Net (Initial Required on Part VI)</b></p> <input type="checkbox"/> HMO <input type="checkbox"/> Medicare Coordinated (Form Required) <input type="checkbox"/> Seniority Plus (Form Required)	<p align="center"><b>Blue Shield</b></p> <input type="checkbox"/> HMO <input type="checkbox"/> HDHP PPO <input type="checkbox"/> Medicare Coordinated HMO (Form Required) <input type="checkbox"/> Medicare Coordinated PPO (Form Required)	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree + 1 Dependent <input type="checkbox"/> Retiree + 2 (+) Dependent
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Open Enrollment</b> <input type="checkbox"/> <b>Change Address</b> <input type="checkbox"/> <b>Add Dependent(s)</b> <input type="checkbox"/> <b>Delete Dependent(s)</b> <input type="checkbox"/> <b>Name Change</b> _____ <span style="margin-left: 300px;">(Former Name)</span>		Retiree Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Part A _____ Part B _____	Spouse Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Part A _____ Part B _____
<b>Event</b> _____ <b>Date of Event</b> _____			

**I. RETIREE INFORMATION**

Last Name	First Name	M.I.	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
Address			City	State	Zip
Physician Name	Medical Group		PCP/Kaiser Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retiree Phone Number

**II.  SPOUSE (IRS Dependent?  Yes  No)       DOMESTIC PARTNER (IRS Dependent?  Yes  No)**

<input type="checkbox"/> HMO <input type="checkbox"/> HDHP Plan <input type="checkbox"/> Medicare Coordinated (Form required) <input type="checkbox"/> Senior Plan (Form required)	Last Name	First Name	M.I.	Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
	Physician Name	Medical Group		PCP/Kaiser Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Group Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No

**III. DEPENDENT CHILDREN INFORMATION**

Last Name	First Name	M.I.	Date of Birth	Social Security Number	Sex	Physician's Name	Medical Group	PCP/Kaiser #	IRS Dependent	Student	Disabled
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Name and Address of Dependent if Different:

**IV. OTHER GROUP COVERAGE INFORMATION**

Insured Name	Insured SSN	Carrier Name	Group Number	Coverage applies to: <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child(ren)
--------------	-------------	--------------	--------------	---

**V. DEDUCTION AUTHORIZATION:** If applicable, I authorize the County of Sacramento to deduct from my retiree pension the required premiums.

**VI. ARBITRATION AGREEMENT (HEALTH NET):** I understand that any dispute or controversy, including medical malpractice, which may arise under the agreement between myself (and/or any enrolled family member) and my chosen health plan and its affiliates, or any participating medical office/group must be submitted to binding arbitration in lieu of a jury or court trial if the amount in dispute exceeds the jurisdictional limits of small claims court. If any such dispute is within the jurisdictional limits of small claims court, the matter will be resolved in small claims court. \_\_\_\_\_ (Initial)

**VII. ARBITRATION AGREEMENT (KAISER PERMANENTE):** I understand that, except for small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the Evidence of Coverage. \_\_\_\_\_ (Initial)

**VIII. PPO Network** If my selection of a medical plan includes a participating provider network, I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**IX. I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. (You are entitled to a copy of this signed authorization for your files.)**

<b>Retiree Signature:</b> _____	<b>Date:</b> _____
---------------------------------	--------------------