



County Of Sacramento Active Employee Health Plan Election Form Instructions and Rates

Employee Benefits Office
700 H Street, Room 6750
Sacramento, CA 95814
Phone: (916) 874-2020
Fax: (916) 874-4621
PSDBenefits@saccounty.net

<http://www.hra.saccounty.net/employ/ben/content.htm>

Open for instructions to complete the election form, rates are on the back page.

Active Employee Health Plan Election Form Instructions

1. Select a medical carrier and plan (turn over for rates on back page)
 - a. If Health Net - initial Part VI ARBITRATION AGREEMENT (HEALTH NET) on health form
 - b. If Kaiser - initial Part VII ARBITRATION AGREEMENT (KAISER) on health form
 - c. If Blue Cross Catastrophic - complete Part IV (OTHER GROUP COVERAGE INFORMATION) on health form
 - i. proof of other group insurance coverage required
2. Select Employee or Family coverage
3. Select New Enrollment – complete employment information
4. Complete employee information (Part I) – Full name, Social, Birth date, current residence, etc
5. Complete Physician information - if left blank or incomplete, the carrier will choose your doctor
 - a. To find a doctor, use the contacts listed on page 27 of the County of Sacramento Summary of Benefits book, or go to <http://www.hra.saccounty.net/employ/ben/content.htm> and click on “health” to find your carrier link.
 - b. If you selected Blue Cross HMO, Health Net HMO, or Blue Shield HMO, complete physician full name, Medical group, and PCP number
 - c. If you selected Kaiser HMO and had previous Kaiser coverage, complete physician full name and Kaiser number.
6. Complete Spouse/Domestic Partner (Part II) and Physician information in the same manner as # 5 above - if left blank or incomplete, the carrier will choose your doctor
 - a. Copy of marriage certificate/California Domestic Partnership Registration form or Dependent Certification Affidavit required
7. Complete Dependent Children information (Part III) and Physician information with full name, medical group, PCP number, etc. (if left blank or incomplete, the carrier may choose your doctor)
 - a. Copy of birth certificate/adoption/legal guardianship or Dependent Certification Affidavit required
 - b. A dependent 19 to 24 years old must be a full-time student -copy of class schedule or County full-time student verification form required
8. Sign and date the medical application form

NOTE: Additional forms are available on our website at <http://www.hra.saccounty.net/employ/ben/content.htm>



ACTIVE 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

Office Use Only

Effective Date _____
 Group Number _____ Certs _____
 Rate Change Yes No Date _____
 Rep Unit _____ Verified _____

Blue Cross <input type="checkbox"/> HMO <input type="checkbox"/> Catastrophic #1	Health Net (Initial Part VI) <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Flex Net #1	Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> PPO #1	Kaiser Permanente (Initial Part VII) <input type="checkbox"/> HMO	<input type="checkbox"/> Employee Only <input type="checkbox"/> With Dependent(s) #2
<input type="checkbox"/> New Enrollment #3 <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address <input type="checkbox"/> Return LOA From _____ To _____			<input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Sacramento County or <input type="checkbox"/> Special District _____	
Event _____ Date of Event _____			<input type="checkbox"/> Are you actively working? <input type="checkbox"/> Yes <input type="checkbox"/> No #3 <input type="checkbox"/> Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Hire Date _____	

I. EMPLOYEE

Last Name #4	First Name	M.I.	Social Security Number #4	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate #4
Address			City #4	State	Zip #4
Physician Name #5	Medical Group	PCP/Kaiser Number #5	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Work Phone	

II. SPOUSE DOMESTIC PARTNER Domestic Partner an IRS Dependent? Yes No

Last Name #6	First Name	M.I.	Social Security Number #6	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate #6
Physician Name			Medical Group	PCP/Kaiser Number #6	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
					Other Group Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No #6

III. DEPENDENT CHILDREN

Last Name	First Name	M.I.	Date of Birth	Social Security Number	Sex	Physician's Name	Medical Group	PCP/Kaiser #	IRS Dependent	Student	Disabled
#7					<input type="checkbox"/> M <input type="checkbox"/> F	#7			<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
					<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 #1	Group Number	Carrier Name	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 my employer to deduct from my wages 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 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) #1

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) #1

VIII. PPO Network If my 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.)

Employee Signature: #8	Date: #8
---	---

TIER B RATES
HIRED ON OR AFTER 1/1/2007

Medical Plan	Monthly Premium	County Paid (Monthly)	EE Paid (Monthly)
Blue Cross HMO			
Employee Only	\$517.58	\$323.34	\$194.24
With Dependents	\$1284.90	\$826.90	\$458.00
Blue Shield HMO			
Employee Only	\$491.36	\$323.34	\$168.02
With Dependents	\$1279.70	\$826.90	\$452.80
Health Net HMO			
Employee Only	\$435.42	\$323.34	\$112.08
With Dependents	\$1113.50	\$826.90	\$286.60
Kaiser HMO			
Employee Only	\$404.18	\$323.34	\$80.84
With Dependents	\$1033.62	\$826.90	\$206.72
Blue Shield PPO			
Employee Only	\$689.22	\$323.34	\$365.88
With Dependents	\$1652.16	\$826.90	\$825.26
Health Net POS			
Employee Only	\$621.24	\$323.34	\$297.90
With Dependents	\$1542.28	\$826.90	\$715.38
Flex Net			
Employee Only	\$991.90	\$323.34	\$668.56
With Dependents	\$2778.32	\$826.90	\$1951.42
*Blue Cross Catastrophic			
Employee Only	\$34.28	\$34.28	\$0
With Dependents	\$87.66	\$87.66	\$0