Internal Benefit Enrollment/Change Form

Action:

☐ Open Enrollment ☐ Status Change effective: _____

☐ New Hire ☐ Add/Delete Dependent

☐ Cancel Coverage ☐ Effective Date of Cancellation

☐ Event Date _____ Reason: _____

☐ COBRA Start Date _____ _____Indicate Qualifying Event Date

Employee Information

First Name: _____ MI: _____ ☐ Male ☐ Female

Last Name: _____ SSN: _____

Hire Date: _____ Hrs/wk: _____ Birthdate: _____

Job Title: _____

Location: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married

Family Information

❶ Relationship: (Spouse) _____ ☐ Disabled ☐ MediCare Eligible

If enrolled in Medicare, please provide copy of ID card

Last Name: _____ First Name: _____

☐ M ☐ F Birthdate: _____ SSN: _____

❷ Relationship: _____ ☐ Disabled ☐ MediCare Eligible

Last Name: _____ First Name: _____

☐ M ☐ F Birthdate: _____ SSN: _____

❸ Relationship: _____ ☐ Disabled ☐ MediCare Eligible

Last Name: _____ First Name: _____

☐ M ☐ F Birthdate: _____ SSN: _____

(Use "Additional Dependents" page to list additional dependents)

Benefit Elections

Medical Plan *(Choose One)*

☐ Anthem PPO #618

☐ Anthem EPO (closed plan) #618

Location Name: _____

Location ID: _____

Tier

☐ Employee Only

☐ Employee + Spouse

☐ Employee + Child(ren) (to age 26 -no student status required)

☐ Employee + Family (to age 26 -no student status required)

Wellness:
Participant ☐ Yes ☐ No

" Authorization to Release Medical Information and Signature;" and "J. Binding Arbitration"

I authorize DHS and its affiliates ("Anthem CA") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmited disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, or other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to DHS and Anthem. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying DHS and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, DHS and Affiliates also request that I acknowledge the following, which I do; I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a joint life and health application and the each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any heath information not included on the Request for Coverage. I (we) understand the the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Signature: _____ Date: _____

Signature

Please maintain a copy of this authorization for your records.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTIVE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND DELTA HEALTH SYSTEMS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDER FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature: _____ Date: _____

Signature Required

Medicare Information-this section completed for coordination of benefits

Are you or any of your dependents currently covered by Medicare? No _____ Yes _____ If yes, please attach a copy of your Medicare card(s) and/or enter the type of coverage here:

Part A: ____ Effective date: ___/___/___ (mm/dd/yyyy) Part B: _____ Effective date: ___/___/____

Is Medicare eligibility due to End State Renal Disease (ESRD)? Yes ____ No ___

If yes, please anwer the following questions:

a) what was the first date of dialysis treatment, and what type of dialysis are you receiving?

Date_____ Type: ___ Hemo ___ Self-dialysis (peritoneal)

b) If you had a kidney transplant, what was the date of the transplant ___/___/___

Other Medical Coverage Information-this section must be completed for Coordination of Benefits

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy?

☐ Yes (continue completing this section)

☐ No (if No, skip this section)

Name of Carrier: _____ Other carrier policy # _____

Other Medical Insurance/Health Plan		**Type**	**Eff Date**	**End Date**	**Name/DOB**
only list those covered by other plan		B/S/F*			
Emp					
Spouse					
Child					
Child					
Child					
Child					

* B means this dependent is covered under both you and your spouse's insurance coverage (married)

*S means you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses

*F means this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses

Benefit Elections

Dental Plan

☐ Premier Access PPO Dental Group #: 100980

☐ Premier Access DHMO Dental Group #: 14863

Premier DHMO Office ID _____ Dentist Name _____

☐ Waive Coverage (Must complete "Waiver of Coverage")

Tier	**Dependent Number(s) Listed in "*Family Information*"**
☐ Employee Only	_____
☐ Employee + Spouse	_____
☐ Employee + Child(ren)	_____ (children to age 19 or 25 if f/time student)
☐ Employee + Family	_____ (children to age 19 or 25 if f/time student)

Vision Plan (tied to medical-cannot be purchased without medical)

☐ Superior Vision Group #: 31013

☐ Waive Coverage (Must complete "Waiver of Coverage")

Tier	Dependent Number(s) Listed in "*Family Information*"
☐ Employee Only	_____
☐ Employee + Spouse	_____
☐ Employee + Child(ren)	_____ (children to age 19 or 25 if f/time student)
☐ Employee + Family	_____ (children to age 19 or 25 if f/time student)

Core Life (employer paid)

☐ Symetra Life and AD&D Group #: 01-016651-00

Employee Life/AD&D Benefit Amount $20,000

Beneficiary Information Covered Person: _____

The beneficiary for the policy shall be:

a)

Primary Beneficiary *	%	Relationship	Address

b)

Contingent Beneficiary	%	Relationship	Address

This beneficiary designation cancels any prior beneficiary designation and shall be effective on the date signed or the date received by the company.

* California law requires your legal spouse to receive 50% of this benefit. If you do not designate 50% to the spouse, she/he will be required to sign an acknowledgement.

Employee Signature: _____ Date: _____

Additional Notices and Signature

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

I request benefits under the group coverage issued by Sun Life and Health Insurance Company (U.S.) and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct to the best of my knowledge and belief and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment may result in my coverage being contested subject to the incontestability provision and that all statements made by me shall be deemed to be representations and not warranties.

IN CALIFORNIA: “Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”

Employee Signature: _____ Date: _____