



- Add Dependent
- Delete Dependent
- Open Enrollment
- Other
- New Hire Enrollment
- Retirement
- Change in Health Plan

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

Event Date: \_\_\_\_\_

**UNIVERSAL BENEFITS ENROLLMENT OR CHANGE WORKSHEET**

**EMPLOYEE INFORMATION – COMPLETE IN FULL**

Employee Name (Last, First, Middle Initial)				Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Social Security No.	Unit:	
<b>Action:</b> <input type="checkbox"/> Add <input type="checkbox"/> Self <input type="checkbox"/> Delete <input type="checkbox"/> Dependent		<b>Coverage:</b> <input type="checkbox"/> Med <input type="checkbox"/> Vision <input type="checkbox"/> Dental		<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> City Domestic Partnered <input type="checkbox"/> State Domestic Partnered		<b>Employee Type:</b> <input type="checkbox"/> FT <input type="checkbox"/> PT   _____ FTE		<b>Department:</b>
Mailing Address:				State:	Zip:	Job Title:		

**LIST ALL DEPENDENTS TO BE ENROLLED IN COVERAGE (See special note below for dependents aged 19-26):**

Last	First	MI	Gender	Birth Date	Social Security No.	Relationship	Action	Coverage
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Natural/Step/Legal Child <input type="checkbox"/> Domestic Partner Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> Student <input type="checkbox"/> Non-Student
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Natural/Step/Legal Child <input type="checkbox"/> Domestic Partner Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> Student <input type="checkbox"/> Non-Student
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Natural/Step/Legal Child <input type="checkbox"/> Domestic Partner Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> Student <input type="checkbox"/> Non-Student
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Natural/Step/Legal Child <input type="checkbox"/> Domestic Partner Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> Student <input type="checkbox"/> Non-Student
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Natural/Step/Legal Child <input type="checkbox"/> Domestic Partner Child	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> No Change	<input type="checkbox"/> Med <input type="checkbox"/> V <input type="checkbox"/> D <input type="checkbox"/> Student <input type="checkbox"/> Non-Student

**SPECIAL NOTES ON CHILD DEPENDENTS (aged 19-26) – All employees wishing to enroll child dependents (aged 19 – 26) in medical coverage under their City of Santa Rosa plan may do so until the dependent reaches 26 years of age. All employees wishing to enroll child dependents (aged 19-26) in dental and vision coverage must confirm full time (9 unit) school enrollment. Completion of a Student Certification form is REQUIRED.**

**MEDICAL, DENTAL & VISION ELECTIONS - PLEASE CHECK APPLICABLE BOX(ES)**

	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY
<input type="checkbox"/> Dental <input type="checkbox"/> Units 2, 5 Group (3066-0018) <input type="checkbox"/> Units 3, 4, 6-18 Group ( 3066-0015) <input type="checkbox"/> Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vision Service Plan (VSP) <input type="checkbox"/> Waive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Plan: <input type="checkbox"/> City EPO <input type="checkbox"/> City PPO <input type="checkbox"/> Kaiser Permanente Traditional HMO Plan: <input type="checkbox"/> Active (GP# 8961-0000) <input type="checkbox"/> Retiree (GP# 8961- 0002) <input type="checkbox"/> Waive (If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HUMAN RESOURCES USE ONLY**

	OLD LEVEL	OLD LEVEL	OLD LEVEL
Medical Plan Level    Change <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Level            Change <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Level            Change <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Copy to Payroll <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Workterra <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ENROLLMENT DECLINATIONS****ADDITIONAL HEALTH/DENTAL COVERAGE**

Coverage is declined for the following people  Self  Spouse Only  Spouse & Child(ren)  
 Child(ren) only because:  the individuals are insured by:

Insurance Carrier: \_\_\_\_\_: OR

Other reasons: \_\_\_\_\_

Secondary/primary health and/or dental coverage exists for  Self  Spouse  
 Only  Spouse & Child(ren)  Child(ren) only

Health Carrier: \_\_\_\_\_ Policy #/Effective Date: \_\_\_\_\_

Dental Carrier: \_\_\_\_\_ Policy #/Effective Date: \_\_\_\_\_

**Authorization to Obtain OR Release Medical Information Explanation:** The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the *Confidentiality of Medical Information Act*, effective January 1, 1980, Section 56 et. Seq., of the *California Civil Code*. Your cooperation is being requested.

**Authorization to Obtain OR Release Medical Information:** I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim. **Initial** \_\_\_\_\_

**Arbitration Agreement:** I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and claims of medical malpractice, (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered,) except for claims subject to *ERISA*, or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration. **Initial if you have selected the City EPO or the City PPO** \_\_\_\_\_

**Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement\***

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes\*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.

\* Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.

\_\_\_\_\_  
**Employee Signature Required for all Kaiser Permanente Plans**  
 (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

\_\_\_\_\_  
**Date**

**(All Plans-EPO, PPO, Kaiser Permanente)**

X

Signature of witness (only required if employee signature is "X")

Date:

**Office Use Only**

Received HR \_\_\_\_\_ By: \_\_\_\_\_ Confirmation Sent to PY on: \_\_\_\_\_

Entered EBS \_\_\_\_\_ By: \_\_\_\_\_

**COPY**

Received PY \_\_\_\_\_ By: \_\_\_\_\_