ENROLLMENT APPLICATION JANUARY–DECEMBER 2017 : CITY & COUNTY OF SAN FRANCISCO EMPLOYEE

You must submit a completed enrollment application and any required documentation to HSS within **30 days** of your initial benefits eligibility date or within **30 days** of a qualified change in family status. Please refer to your HSS Benefits Guide or visit myhss.org for details.

1 APPLICATION TYPE

☐ New Hire ☐ Rehire/Reinstatement

Status Change: ☐ Birth/Adoption ☐ Marriage/Partnership ☐ Divorce/Separation/Dissolution ☐ Ineligible ☐ Other Coverage ☐ Other ______

2 YOUR PERSONAL INFORMATION

Last Name	First Name	Initial

Street Address (no P.O. boxes)	City	State	Zip Code

Employee (DSW) ID Number	Social Security Number	Birth Date MM/DD/YYYY	Gender M/F	Home / Cell Telephone Number

eMail Address	Work Telephone Number

3 CHOOSE YOUR MEDICAL PLAN (INCLUDES VSP VISION COVERAGE)

☐ Blue Shield HMO* ☐ Kaiser HMO* ☐ City Plan PPO

☐ No Medical/Vision Coverage

*To enroll in an HMO plan you must live in an area serviced by the HMO.

4 CHOOSE YOUR DENTAL PLAN

☐ Delta Dental PPO ☐ UnitedHealthcare Dental DMO*

☐ Deltacare USA DMO* ☐ No Dental Coverage

*To enroll in a DMO plan you must live in an area serviced by the DMO.

5 TO ADD OR DROP DEPENDENTS FROM YOUR MEDICAL AND/OR DENTAL COVERAGE, PLEASE LIST BELOW.

You must submit required eligibility documentation for the initial enrollment of any dependents. See the reverse side of this form for details.

Medical	Dental	Last Name	First Name	Birth Date MM/DD/YYYY	M/F	Social Security Number	Relationship
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						

6 DO YOU WANT A FLEXIBLE SPENDING ACCOUNT (FSA)?

☐ Yes, I want a Healthcare Flexible Spending Account. I want to contribute a total annual amount of $ ______ January–December 2017.
(Annual amount divided by 25 or remaining number of pay periods will equal bi-weekly payroll deduction for January–December 2017.) (Min $250 - Max $2,500)

☐ Yes, I want a Dependent Care Flexible Spending Account. I want to contribute a total annual amount of $ ______ January–December 2017.
(Annual amount divided by 25 or remaining number of pay periods will equal bi-weekly payroll deduction for January–December 2017.) (Min $250 - Max $5,000)

7 SIGNATURE & CERTIFICATION

Under penalty of perjury I certify that the information entered on this document is true and correct. I give the persons administering the plans in which I enroll and/or their agents permission to verify all information. It is my responsibility to notify the Health Service System (HSS) when a dependent becomes ineligible. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify plans and HSS for any benefits paid if I or my dependents prove to be ineligible. I understand falsification of information may violate applicable laws, rules and regulations, leading to dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form. A copy of this form is as valid as the original.

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: Date Signed:

Mail or drop off this form in person to: HSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103 Member Services Phone: 1-415-554-1750

Fax forms to: 1-415-554-1721 Please do not fax the same application multiple times. **Keep a copy of this form for your records.**

HSS USE ONLY Enrolled by: ______ Date: ______ Processed by: ______ Date: ______

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:

- The Health Service System will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- You agree to complete and submit to the plan provider any necessary forms, consents, releases, assignments, applications, questionnaires and other documents that the plan or HSS may reasonably request.
- **You authorize the Health Service System to deduct during each applicable coverage period from wages due you any contributions required on your part to provide healthcare coverage for yourself and any eligible dependents listed on this form, and to remit such amounts to the benefit plans you have designated.** This deduction may also include contribution amounts which are delinquent and due to the Health Service System.
- You agree to submit any contribution required on your part directly to the Health Service System during any unpaid leave of absence.
- Your participation in the Health Service System is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the Health Service System), as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during January–December 2017 unless you have a qualifying family status change. Refer to your Benefits Guide for complete details.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to reimbursement of premium and claims costs on a retroactive basis, disciplinary action, dismissal and/or legal action.
- The terms and conditions of each medical/dental plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by the Health Service System, the terms and conditions of the plan documents will govern.
- You understand that **some of the health plans offered by the health service system contain a clause requiring resolution of medical malpractice and other disputes through binding arbitration**. This clause expressly provides that when you select the applicable plan, you give up the right to a jury or court trial for resolution of these disputes. To determine whether the plan you have selected contains such a clause and, if so, what the exact terms and conditions of such clause are, consult the individual plan document available through applicable Plan Provider.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the Health Service System, you will promptly notify the Health Service System and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by HSS.
- The following documentation is required, in addition to a completed HSS Health Benefits Enrollment Application, for any eligible individual's enrollment. HSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■								■
Employee: Temporary/Exempt									■
Spouse		■							■
Domestic Partner			■						■
Child: Natural				■					■
Step Child: Spouse		■		■					■
Step Child: Domestic Partner			■	■					■
Child: Adopted					■				■
Child: Placed for Adoption						■			■
Child: Legal Guardianship							■		■
Child: Court Ordered							■		■
Adult Child: Disabled				■				■	■

Note: Proof of Medicare enrollment is also required for a legal domestic partner or disabled child who is Medicare eligible.

If you have questions about eligibility or required documentation contact HSS Member Services at 1-415-554-1750.