

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

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

- The San Francisco Health Service System (SFHSS) 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 SFHSS may reasonably request.
- **You agree to submit any contribution required on your part and authorize SFHSS to deduct from your wages any contributions required on your part to provide healthcare coverage for yourself and any enrolled dependents. These amounts will be paid to the benefit plans you have selected. The deductions will occur during each coverage period, typically each pay period. This deduction may also include past due amounts.**
- You agree to submit any contribution required on your part directly to SFHSS.
- Your participation in the SFHSS is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of SFHSS 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 2019 unless you have a qualifying family status change. Refer to your Benefits Guide for complete details.
- Any misrepresentation 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 SFHSS, the terms and conditions of the plan documents will govern.
- You understand that **some of the health plans offered by SFHSS 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 SFHSS, you will promptly notify SFHSS and submit all requested documentation. Dependent eligibility may be audited by SFHSS and proof of dependent eligibility may be required at any time.
- You understand that you or any dependent listed on this form who has End Stage Renal Disease may be prohibited by law from changing health plan enrollment.
- 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 SFHSS.
- Any of the health plans offered by SFHSS may require documented verification of any Disabled Adult Child Dependent.
- The following documentation is required, in addition to a completed SFHSS Health Benefits Enrollment Application, for any eligible individual's enrollment. SFHSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTATION

In addition to social security numbers for each eligible plan participant, you must also supply the following documentation listed below.

	CERTIFIED MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	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 (Up to Age 19)						■	■
Child: Court Ordered (Up to Age 19)						■	■

Proof of Medicare enrollment is also required for a legal domestic partner who is Medicare eligible due to age or disability.

If you have questions about eligibility or required documentation contact SFHSS Member Services at (415) 554-1750.