

SDCERA

Strength. Service. Commitment.

Medical & Dental Plan
Enrollment/Disenrollment form

For Retired Members

Medical & Dental Plan Instructions for Enrollment/Disenrollment form

SECTION 1: EVENT TYPE

Select all options that apply to your situation. Review the following to determine which option(s) to select.

- Annual Open Enrollment is held in November each year and is the time when you are able to enroll or make changes/additions to your plan. Enrollment or changes/additions become effective January 1 of the following year.
- Changes outside of Open Enrollment must be within 30 days of a qualifying event. Qualifying events include termination of coverage by your employer, retirement, marriage, divorce, death, relocation out of area, or becoming Medicare eligible. If this applies to you, make the selection and check the box for your enrollment or change outside of annual Open Enrollment. You must attach documentation as proof of the qualifying event. Changes become effective the first day of the month following SDCERA's receipt of your form and documentation.
- You may cancel your existing plan at any time outside of Open Enrollment. If you are canceling your plan, make this selection and indicate the effective date of your cancellation.

SECTION 2: MEMBER INFORMATION

Make one selection and include your personal information—please print clearly.

SECTION 3: MEDICAL PLAN INFORMATION

Check the enrollment box next to your medical plan selection to enroll in the plan. Check the cancel box next to your current plan to cancel your current coverage. You may check more than one box, if applicable.

All plans shown are available to all members who live within the plan's service area. Contact the plan first to determine if you live within the service area. Three plans are available to members who live outside of California: UnitedHealthcare PPO (formerly known as PacifiCare PPO) and UnitedHealthcare Senior Supplement (formerly known as PacifiCare Senior Supplement) are available nationwide; Secure Horizons is available to residents in California, Arizona and Nevada.

Medicare

Only complete the Medicare section if you are (or your dependent is) eligible for Medicare. SDCERA requires information about your enrollment date(s). In addition, you must submit a copy of your signed Medicare card to SDCERA. If you are (or your dependent is) in the process of enrolling in Medicare, please submit a copy of your signed Medicare card as soon as you receive it.

Important: If you enroll (or your dependent enrolls) in Kaiser Permanente Senior Advantage, Health Net Seniority Plus or Secure Horizons, you must complete and submit a Medicare assignment form to SDCERA prior to the month of your enrollment in Medicare. Health Net Seniority Plus and Secure Horizon enrollees must contact the SDCERA Call Center to request the form. Kaiser Permanente will automatically mail the form directly to Senior Advantage enrollees. If you do not submit this additional form to SDCERA, you may be charged a higher rate for your plan's coverage and in some cases a delay could cause loss of coverage.

SECTION 4: DENTAL PLAN INFORMATION

Check the enrollment box next to your dental plan selection to enroll in the plan. Check the cancel box next to your current plan to cancel your coverage. You may check both an enrollment and a cancel box, if applicable.

All plans shown are available to all members regardless of whether or not you live in California; however, you must live within the plan's service area. Contact the plan first to determine if you live within the service area.

SECTION 5: COVERAGE INFORMATION

Please complete a line in this section for yourself and for each dependent you enroll. To enroll in a medical plan, mark an X in the medical column. To enroll in a dental plan, mark an X in the dental column. Mark an X in both columns if you are enrolling in both a medical and a dental plan. List yourself first. If you need additional space, attach a separate sheet of paper and return it with your form.

SECTION 6: AUTHORIZATION

Sign and date in this section after you have read the authorization on the reverse side of the form.

Submit the completed form to SDCERA. If you are enrolling in a plan, the plan will send you an informational packet including a membership card.

SECTION 1: EVENT TYPE *Check all options that apply.*

- Annual Open Enrollment**
 Canceling existing coverage / Effective month/year: _____
- Enrolling outside of Open Enrollment due to (please choose one)** / Effective month/year: _____
- retirement
 marriage*
 divorce*
 death
- termination of coverage by employer*
 relocation out of area
 Medicare eligible*
 *Attach supporting documentation

SECTION 2: MEMBER INFORMATION

First name	MI	Last name	Social Security number
Street address	City	State	ZIP
			Daytime telephone number ()

Retired, making a change or canceling current coverage
 Retired, enrolling for the first time / Retirement date: _____

Surviving spouse/domestic partner or eligible child of a deceased member / Deceased member's SSN: _____

SECTION 3: MEDICAL PLAN INFORMATION

ENROLL	CANCEL	Kaiser Permanente	ENROLL	CANCEL	PacifiCare/UnitedHealthcare	ENROLL	CANCEL	Health Net
		HMO (#104302)			Signature Value HMO (#004501)			HMO (#57358-A)
		Senior Advantage (#104302-00)			Secure Horizons (#004497)			HMO Medicare non-assignment (#57358-B)
		"M" Coverage (closed to new enrollees)			Choice Plus PPO (#717697)			Seniority Plus (#57358-S)
N/A					Senior Supplement (#00014829)			

Medicare (if eligible)

- I am enrolled
 Medicare ID Number _____
 Part A effective date _____
 Part B effective date _____
- My dependent is enrolled
 Medicare ID Number _____
 Part A effective date _____
 Part B effective date _____
- I am in the process of enrolling
- My dependent is in the process of enrolling

SECTION 4: DENTAL PLAN INFORMATION

ENROLL	CANCEL	CIGNA Dental	ENROLL	CANCEL	Delta Dental
		DHMO (#3217340)			Preferred PPO (#2472-1)

SECTION 5: COVERAGE INFORMATION

MEDICAL Mark with an 'X'	DENTAL Mark with an 'X'	Full name			Relationship	Sex (M/F)	Birth date	Social Security number
		First	MI	Last				
					Self		/ /	
							/ /	
							/ /	
							/ /	

SECTION 6: AUTHORIZATION

I have read, agree and understand the authorization section on the reverse side of this form. By signing below, I elect coverage as I have indicated above.

Signature	Date
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YOUR AUTHORIZATION

I elect to be covered under the medical and/or dental plan(s) I have indicated on the reverse side of this form in Section 3 and 4, unless I make another selection during a future Open Enrollment period or revoke this choice in writing. I understand the provisions of the choice I have selected.

I agree to have my monthly retirement payment reduced by the required amount to pay my share of the cost for the medical and/or dental plan(s) I have selected and I authorize payment of medical and/or dental benefits to the plan or care provider I have chosen. I also authorize the plan or care provider to release any or all medical information for myself or covered dependents when information is needed to process claims.

I have read and understand the information contained in the SDCERA *Health Insurance Plans* booklet and I understand that the SDCERA Board of Retirement reserves the right to modify or terminate the health insurance plans for my insurance coverage.

FOR KAISER PERMANENTE PLANS ONLY

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, 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 for any duty arising out of and related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by law suit or resort to court process, except as applicable law proves 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 full arbitration provision is contained in the Evidence of Coverage.

FOR HEALTH NET, PACIFICARE, SECURE HORIZONS OR UNITEDHEALTHCARE

Enrollment in a Health Net, PacifiCare, Secure Horizons or UnitedHealthcare medical plan constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any injury or court trail. Refer to the enrollment information for the plan you enroll in to determine if and what types of disputes apply to the arbitration process. If this provision applies, your signature on the reverse side of this form means you agree to such arbitration for yourself and your enrolled dependents.

FOR CIGNA DENTAL OR DELTA DENTAL

Enrollment in CIGNA Dental or Delta Dental constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any injury or court trail. Refer to the enrollment information for the plan you enroll in to determine if and what types of disputes apply to the arbitration process. If this provision applies, your signature on the reverse side of this form means you agree to such arbitration for yourself and your enrolled dependents.