# Stanislaus County Universal Enrollment/Change Form

Please complete this form in its entirety when enrolling or making changes. Refer to your Benefits Summary for information on your benefit options. Check the option for each of your choices. Enter the dependent information if necessary. Indicate your Primary Care Physician's Name and ID#. You will also need to complete a County Benefit Enrollment form for an option code change. If there is a Family Status Change, you must return completed forms within 30 days of the qualifying event.

## Employee General Information

| ☐ Open Enrollment | ☐ New Hire | ☐ Change in Status | Effective Date: / / | Reason: | Emplid: |
|---|---|---|---|---|---|

| Last Name | First Name | New Last Name (If applicable) | MI |
|---|---|---|---|

| Address | City | State | Zip Code |
|---|---|---|---|

| Phone# Home Work | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married | Date of Birth / / |
|---|---|---|---|
| Social Security No. – – | | | Date of Hire / / |

## Medical/Dental/Vision Plan Election

| Medical | Dental | Vision |
|---|---|---|
| ☐ Health Plan of San Joaquin GRP # STC-NET01 | ☐ Stanislaus Dental Foundation GRP # 3001 | ☐ Vision Service Plan GRP # 0045000-0002 |
| ☐ Kaiser Permanente GRP # 37295 | | |
| ☐ PacifiCare HMO GRP # 403218 | | |
| ☐ PacifiCare POS GRP # 513272 | | |

## Dependent Information

List <u>all</u> family members to be covered each time you complete this form. Attach separate sheet for additional dependents.*
Please indicate primary care physician's name and ID#, if not complete, you will be automatically assigned. For a list of physicians, refer to the directory provided.

**Select coverage for each dependent**

| Last Name First Name | Social Security Number | Relationship | Date of Birth | Sex | If change (check one) Add | Delete | Primary Physician Name | Primary Physician ID# (Not required for Kaiser) | Established Patient Yes | No | Medical | Dental | Vision |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Employee | Included Above | Self | N/A | N/A | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. | | Spouse | | | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. | | | | | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. | | | | | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. | | | | | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. | | | | | ☐ | ☐ | | | ☐ | ☐ | ☐ | ☐ | ☐ |

***Dependents age 19 and over require a <u>Certification of Dependent Status Eligibility</u> form be completed to indicate full-time student status or permanent disability.**

| Name | Social Security No. – – |
|---|---|

**Coordination of Benefits (New Hires Only)**

Do you or any of your dependents have previous health insurance coverage? ☐ Yes ☐ No Still enrolled? ☐ Yes ☐ No

| Name of Employee/Dependent Last Name | First Name | Name of Other Insurance Carrier/Health Plan | ID Number/ Medical Record Number | Employer |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

**Employee Acceptance --Please read the following and acknowledge by signing below:**

I hereby apply for group benefits provided under my employer's group benefit plan(s) for myself and for the eligible dependents listed on this form. I understand that I have made an election for my benefits package for the Plan Year indicated on this Universal Enrollment Form. Any choices I have made may only be altered as the result of a change in family status.
I have read and understand the provisions outlined in this form including, but not limited to the arbitration clause and my signature below acknowledges my understanding and acceptance of these terms. All information on this form is correct and true to the best of my knowledge. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I am entitled to a copy of this signed authorization for my files.

I declare for myself and/or my dependent(s) that I am eligible to enroll in these plans and request to be covered. If the group plan provides that contributions be made by me, I authorize Stanislaus County to deduct them from my pay. Should changes take place affecting these statements, I will immediately inform my employer of the change. I understand an agent cannot guarantee coverage or revise rates, benefits or plan provisions without written approval from the specific carrier. Employee personal information is protected under Federal HIPAA Law.

**ARBITRATION AGREEMENT (for Kaiser and HPSJ Participants):** 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 of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 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.

ARBITRATION AGREEMENT (**for PacifiCare Participants**): I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE 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, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN) INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA OR ANY OF ITS PARENTS, SUBSIDARIES 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 PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT 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 |
|---|---|