



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 level change. If there is a Family Status Change, you must return completed forms within 30 days of the qualifying event.

Employee General Information

<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> 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 <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single	Date of Birth / /		
Social Security No. - -		<input type="checkbox"/> Female	<input type="checkbox"/> Married	Date of Hire / /		

Medical/Dental/Vision Plan Election

Medical <input type="checkbox"/> Kaiser Permanente HMO GRP # 37295-0013 <input type="checkbox"/> Kaiser Permanente High Deductible Plan GRP # 37295-0033 <input type="checkbox"/> Anthem Blue Cross HMO GRP # 275366H001 <input type="checkbox"/> Anthem Blue Cross High Deductible Plan GRP # 275366M001	Dental <input type="checkbox"/> Delta Dental PPO Premier GRP # 3351	Vision <input type="checkbox"/> Vision Service Plan GRP # 0045000-0002
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Dependent Information

List all family members to be covered each time you complete this form. Attach separate sheet for additional dependents.*

If enrolling in the Anthem Blue Cross HMO plan, please indicate primary care physician's name and ID#. For a list of physicians, refer to the online directory.

Select coverage for each dependent

Last Name	First Name	Social Security Number	Relationship	Date of Birth	Sex	If change (check one)		Primary Physician Name	Primary Physician ID#	Established Patient		Medical	Dental	Vision
						Add	Delete			Yes	No			
1. Employee		Included Above	Self	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			Spouse			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.						<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.						<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.						<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.						<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Name	Social Security No.	-	-
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Coordination of Benefits (Dual coverage may not be allowed if enrolled in the High Deductible Plan)

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

Name of Employee/Dependent		Name of Other Insurance Carrier/Health Plan	ID Number/ Medical Record Number	Employer
Last Name	First Name			
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 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 Anthem Blue Cross Participants): I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision. IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, 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 arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS IS WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature	Date
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