OPEN ENROLLMENT 2020 EMPLOYEE HEALTH INSURANCE APPLICATION

EFFECTIVE DATE: 12 / 16 / 2019
RECEIVED BY:
ENTRY DATE: ENTERED BY:

OPEN ENROLLMENT HEALTH INSURANCE APPLICATIONS AND SUPPORTING DOCUMENTS ARE DUE TO HUMAN RESOURCES EMPLOYEE BENEFITS DIVISION BY 5:00 PM ON NOVEMBER 8, 2019.

Email: HRBenefits@fresnocountyca.gov **Phone:** (559) 600 - 1810 **Fax:** (559) 455 - 4787

Address: 2220 Tulare Street, 14th Floor, Fresno, CA 93721 **Website:** www.co.fresno.ca.us/openenrollment

EMPLOYEE INFORMATION: *Complete all information.*

Last Name:________________ First Name:________________ Employee ID:__________

SSN:________________ DOB:____________ Phone Number:________________

Email Address: ________________________________

TYPE OF ENROLLMENT / CHANGE: *Check all that apply.*

- ☐ **Enroll Dependent**
- ☐ **Remove Dependent**
- ☐ **Dental Plan Change**
- ☐ **Medical Plan Change**
- ☐ **Enroll (Previous Opt Out)**
- ☐ **Other:** ________________________________

DENTAL PLANS: *If applicable, please select one only if you wish to make a change between plans. Please leave blank if no change.*

☐ **Delta Dental DPPO** ☐ **DeltaCare USA DHMO** Provider Number (DHMO ONLY): ____________ Existing Patient: ☐ Yes ☐ No

Six-digit provider number needed if you wish to be assigned to a specific DHMO provider.

MEDICAL PLANS: *If applicable, please select one only if you wish to make a change between plans. Please leave blank if no change.*

☐ 1: Kaiser Permanente

Read and Sign the Kaiser Arbitration Agreement on page two (2) when choosing Kaiser.
Medical, Mental Health, Prescription, Vision coverage are all through Kaiser.
Deductible Period: No Deductible

☐ 2: Anthem Blue Cross EPO

Medical: Anthem Blue Cross
Mental Health: Anthem Blue Cross
Prescription: EmpiRx
Vision: Vision Service Plan (VSP)
Deductible Period: No Deductible

☐ 3: Anthem Blue Cross PPO 250

Medical: Anthem Blue Cross
Mental Health: Anthem Blue Cross
Prescription: EmpiRx
Vision: Vision Service Plan (VSP)
Deductible Period: Plan Year

☐ 4: Anthem Blue Cross PPO 1000

Medical: Anthem Blue Cross
Mental Health: Anthem Blue Cross
Prescription: EmpiRx
Vision: Vision Service Plan (VSP)
Deductible Period: Plan Year

☐ 5: Anthem Blue Cross HDPPO 1500

Medical: Anthem Blue Cross
Mental Health: Anthem Blue Cross
Prescription: Anthem Blue Cross
Vision: Vision Service Plan (VSP)
Deductible Period: Calendar Year

☐ 6: Anthem Blue Cross HDPPO 3000

Medical: Anthem Blue Cross
Mental Health: Anthem Blue Cross
Prescription: Anthem Blue Cross
Vision: Vision Service Plan (VSP)
Deductible Period: Calendar Year

X SIGNATURE: ________________________ **DATE:** __________

By signing, I hereby enroll or authorize the changes indicated on this form. I also agree to and understand the plan design of my chosen plan, including any copays or deductibles therein. If enrolling in an Anthem Blue Cross plan, by signing, I also agree to the Anthem Blue Cross Arbitration Agreement on the reverse side. If enrolling in a Kaiser Permanente plan, I must also sign the Kaiser Foundation Health Plan Arbitration Agreement on the reverse side.

FORM CONTINUED ON NEXT PAGE

HEALTH INSURANCE DEPENDENTS: *Supporting documentation required to enroll (marriage and birth certificates, etc.).*

❑ **Enroll** ❑ **Remove** Last Name:______________________ First Name:______________________

DOB:____________ Relationship:______________ ❑ M / ❑ F SSN:______________________

❑ **Enroll** ❑ **Remove** Last Name:______________________ First Name:______________________

DOB:____________ Relationship:______________ ❑ M / ❑ F SSN:______________________

❑ **Enroll** ❑ **Remove** Last Name:______________________ First Name:______________________

DOB:____________ Relationship:______________ ❑ M / ❑ F SSN:______________________

❑ **Enroll** ❑ **Remove** Last Name:______________________ First Name:______________________

DOB:____________ Relationship:______________ ❑ M / ❑ F SSN:______________________

❑ **Enroll** ❑ **Remove** Last Name:______________________ First Name:______________________

DOB:____________ Relationship:______________ ❑ M / ❑ F SSN:______________________

❑ **Check this box if you are submitting the Health Insurance Additional Dependent Election form.**

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*.

____ ______________

Additional Signature Required for Kaiser Permanente Plan **DATE**

ANTHEM BLUE CROSS ARBITRATION AGREEMENT:

The following provision does not apply to class actions. IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITATION 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 JUSRISDICTIONAL 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 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 necessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by 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 this arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTIVE 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.

Payroll Adjustment: ***EMPLOYEE BENEFITS PERSONNEL USE ONLY.***

Refund / Collect: $ ____________ Incorrect: _______/_______ Correct:_______/_______ PID(s):________________ # of PPs:____________

Comments: ____