(Benefits Unit to complete)

Retiree ID# _____

County of Sonoma
Retiree Benefits Enrollment/Change Form

Section 1: Retiree/Survivor's Personal Information

Effective Date: _____

Last Name	First Name	Middle Name

Social Security Number	Date of Birth	Gender	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Registered Domestic Partner

Is your spouse, registered domestic partner, or dependent a County of Sonoma Employee or Retiree?	☐ Yes ☐ No	If yes, list name(s)

Residential Address (Required) ☐ Check Box If New Address	City	State	Zip Code

Mailing Address ☐ Check Box If Same As Residential	City	State	Zip Code

Primary Phone ☐ Cell ☐ Home	Alternate Phone	Email Address

Section 2: Reason for Enrollment or Change

Select One:

☐ New Retiree Retirement Date: _____	☐ New Survivor Date of Retiree's Death: _____
☐ Mid-Year Change (Select One Below) Event Date: _____	☐ Annual Enrollment Benefit Effective: June 1, _____

Mid-Year Changes Only (Add, Change and Drop/Cancel):

Add Coverage	
☐ Loss of Other Group Coverage	☐ Medicare Enrollment
☐ Marriage or Registration of Domestic Partnership	☐ Loss of Medicaid or SCHIP
☐ Birth/Adoption/Legal Guardianship	

Change Coverage	
☐ Medicare Enrollment	☐ Moved out of Service Area

Drop/Cancel Coverage	
Voluntary Cancel (Medical and Life Only) ☐ Self ☐ Dependent ☐ Self and Dependent	☐ Moved out of Service Area
☐ Death of Spouse, Registered Domestic Partner or Dependent	☐ Gain Other Group Coverage
☐ Loss of Medicare	

DROP/CANCEL COVERAGE - I am electing to Drop/Cancel coverage for myself and/or my dependent(s). A Retiree who drops or cancels Medical coverage forfeits their opportunity to enroll in a County offered Medical plan in the future. A Retiree who drops or cancels Life Insurance forfeits their opportunity to enroll in County offered Life Insurance in the future. Initial here _____ to confirm your understanding of dropping or cancelling Medical, and Life Insurance coverage.

Section 3: New Retiree Initial Election Only (See section 4 if this is not your initial enrollment)

Medical:	**Self**	**Spouse or Registered Domestic Partner** ☐N/A	**Dependent(s)** ☐N/A
Enroll	☐	☐	☐
Primary Care Physician (PCP) ID# *(only if newly electing Sutter Health Plus or Western Health Advantage):*			
Waive	☐	☐	☐
WAIVING COVERAGE - I am electing to waive medical coverage for myself and/or my dependent(s) as I/we have other group coverage and are not yet Medicare eligible. The option to waive coverage is a **one-time option** available only at the time of retirement or upon initial eligibility for newly eligible dependents. A retiree or spouse/registered domestic partner who waives coverage has no annual enrollment rights and can only enroll in County offered medical benefits upon loss of Group Coverage and not later than initial eligibility of Medicare. Medicare eligible Retirees and/or Medicare eligible spouse/registered domestic partners are not eligible to waive medical coverage. See Declining Coverage below if you and/or your spouse/registered domestic partner are Medicare eligible. Initial here _____ to confirm your understanding of waiving your medical option. If waiving medical coverage for yourself and/or your eligible dependent(s), you must also complete the Waiver of Medical Plan Acknowledgement (Section 9).			
Decline	☐	☐	☐
DECLINING COVERAGE - I am electing to decline medical coverage for myself and/or my dependents. A retiree who declines coverage forfeits their opportunity to enroll in a County offered medical plan now and in the future. Initial here ____ to confirm your understanding of declining your medical options.			

Dental:	**Self**	**Spouse or Registered Domestic Partner** ☐N/A	**Dependent(s)** ☐N/A
Enroll	☐	☐	☐
Waive	☐	☐	☐

Life Insurance: – *Retiree Only at time of Initial Enrollment*	
☐ $10,000	☐ Decline
LIFE INSURANCE CAN ONLY BE ELECTED AT THE TIME OF RETIREMENT You must designate a beneficiary to receive payment of this benefit in the event of your death. Beneficiaries can be updated any time. To obtain a Beneficiary Designation Form contact the County of Sonoma Human Resources Benefits Unit at 707-565-2900 or benefits@sonoma-county.org.	

Section 4: Continuing Retiree or Survivor Enrollment Elections

Self-Elections: – *Dependent elections to be made in Section 7*			☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Drop/Cancel
Primary Care Physician (PCP) ID# *(only if newly electing Sutter Health Plus or Western Heath Advantage):*				
Dental	☐ Continue	☐ Add	☐ Waive	☐ Drop/Cancel
Life – *Retiree Only*	☐ Continue	☐ Drop/Cancel		

Section 5: Dental Coverage Level

Delta Dental: - *(If not making any changes, select your current election)*		
☐ Retiree	☐ Retiree + 1	☐ Retiree + 2 or More
☐ Delta PPO – California and Nationwide	☐ DeltaCare USA HMO – California Only	

Section 6: Medical Plan and Coverage Level

Medical Coverage Level – *(If not making any changes, select your current election)*		
☐ Retiree	☐ Retiree + 1	☐ Retiree + 2 or More

Non-Medicare (Retiree and All Dependents)			
County Health Plans			
☐ CHP PPO – California	☐ CHP PPO – Out-of-State	☐ CHP EPO - California	☐ CHP EPO – Out-of-State
Kaiser Permanente - California			
☐ Traditional HMO	☐ Hospital Services DHMO	☐ Deductible First HDHP	
Kaiser Permanente - Out-of-State Plans			
☐ Traditional HMO - Northwest	☐ HMO - Hawaii		
Sutter Health Plus - Northern California			
☐ Traditional HMO	☐ Hospital Services DHMO	☐ Deductible First HDHP	
Western Health Advantage - Northern California			
☐ Traditional HMO	☐ Hospital Services DHMO	☐ Deductible First HDHP	

Medicare (Retiree and All Dependents)		
Anthem Medicare Preferred (PPO) Medical and Prescription Drug		
☐ Medicare Advantage Plan with Senior Rx Plus		
Kaiser Permanente		
☐ Senior Advantage – California	☐ Senior Advantage - Northwest	☐ Senior Advantage - Hawaii
UnitedHealthcare (UHC- AARP) – Must be 65+ and enrolled in Medicare - U.S.		
☐ UnitedHealthcare AARP Medicare Supplemental Insurance & AARP MedicareRx – Prescription Drug Plan		
If you elected UnitedHealthcare through UHC AARP Telephone Enrollment at (877) 558-4759, enter membership and confirmation numbers below for Self and Dependent as applicable.		
Self - UHC AARP Membership Number:	Rx Confirmation Number:	
Dependent - UHC AARP Membership Number:	Rx Confirmation Number:	

Non-Medicare and Medicare (Retiree and All Dependents)			
CHP/Anthem Medicare - Non-Medicare participants in a family will be enrolled in the CHP EPO or PPO plan of their choice. Medicare participants in the same family will be enrolled in the Anthem Medicare Preferred (PPO) Medical and Prescription Drug plan. **Select the CHP plan your non-Medicare dependents will be enrolled in below.**			
County Health Plan/Anthem Medicare Preferred (PPO) Medical and Prescription Drug			
☐ CHP PPO - California	☐ CHP PPO - Out-of-State	☐ CHP EPO - California	☐ CHP EPO - Out-of-State
Kaiser Permanente and Western Health Advantage allow families with Medicare and non-Medicare dependents to enroll in different plans. **Select the plan your non-Medicare dependents will be enrolled in below.** Medicare participant(s) will default to the corresponding Senior Advantage or Medicare Advantage plan for the provider selected.			
Kaiser Permanente – California			
☐ Traditional HMO	☐ Hospital Services DHMO	☐ Deductible First HDHP	
Kaiser Permanente - Hawaii			
☐ Traditional HMO			
Kaiser Permanente - Northwest			
☐ Traditional HMO			

Section 7: Dependent Information

Spouse or Registered Domestic Partner				☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel
Dental	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel

Last Name	First Name	Middle Name	Relationship

Social Security Number	Date of Birth	Gender	Permanently Disabled?	Primary Care Physician (PCP) ID # *(only if newly electing Sutter or WHA):*
		☐ Male ☐ Female	☐ Yes ☐ No	

Mailing Address (if different from Retiree)

Dependent				☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel
Dental	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel

Last Name	First Name	Middle Name	Relationship

Social Security Number	Date of Birth	Gender	Permanently Disabled?	Primary Care Physician (PCP) ID # *(only if newly electing Sutter or WHA):*
		☐ Male ☐ Female	☐ Yes ☐ No	

Mailing Address (if different from Retiree)

Dependent				☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel
Dental	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel

Last Name	First Name	Middle Name	Relationship

Social Security Number	Date of Birth	Gender	Permanently Disabled?	Primary Care Physician (PCP) ID # *(only if newly electing Sutter or WHA):*
		☐ Male ☐ Female	☐ Yes ☐ No	

Mailing Address (if different from Retiree)

Dependent				☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel
Dental	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel

Last Name	First Name	Middle Name	Relationship

Social Security Number	Date of Birth	Gender	Permanently Disabled?	Primary Care Physician (PCP) ID # *(only if newly electing Sutter or WHA):*
		☐ Male ☐ Female	☐ Yes ☐ No	

Mailing Address (if different from Retiree)

Dependent				☐ **Enrolled in Medicare**	
Medical	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel
Dental	☐ Continue	☐ Add	☐ Waive	☐ Decline	☐ Drop/Cancel

Last Name	First Name	Middle Name	Relationship

Social Security Number	Date of Birth	Gender	Permanently Disabled?	Primary Care Physician (PCP) ID # *(only if newly electing Sutter or WHA):*
		☐ Male ☐ Female	☐ Yes ☐ No	

Mailing Address (if different from Retiree)

SECTION 8: Required Signatures
(If electing a Medical Plan, sign the appropriate Plan Agreement)

County Health Plan Agreement: Preferred Provider Organization (PPO) and Exclusive Provider Organization (EPO)

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

REQUIREMENT FOR BINDING ARBITRATION ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, 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, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.

YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.

Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Retiree/Survivor Signature _____ Date _____

Kaiser Permanente Benefit Plan Agreement:
Traditional HMO/Senior Advantage, Hospital Services DHMO, or Deductible First HDHP

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.

Retiree/Survivor Signature _____ Date _____

Sutter Health Plus Member Agreement:
Traditional HMO, Hospital Services DHMO, or Deductible First HDHP

Sutter Health Plus Binding Arbitration Agreement

Sutter Health Plus handles and resolves member disputes through grievance, appeal, and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including 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 small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns 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.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Evidence of Coverage and Disclosure Form.

_____ _____

Retiree/Survivor Signature Date

Western Health Advantage Arbitration Agreement:
Traditional HMO, Hospital Services DHMO, or Deductible First HDHP

Western Health Advantage Arbitration Agreement

By signing below, I acknowledge that I have read, understand, and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING 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 SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, 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 CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION 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.

_____ _____

Retiree/Survivor Signature Date

SECTION 9: Retiree Waiver Policy Acknowledgement and Signature

Retiree signature and date is required for any waive of retiree or dependent enrollments and changes.

Retiree Waiver Policy Acknowledgement

Retiree medical coverage provisions are outlined in the County of Sonoma Salary Resolution No 95-0926. In order to maintain eligibility for a County contribution and to participate in a County-offered retiree medical plan, an eligible retiree must enroll in a County offered retiree medical plan at the time of retirement unless the retiree waives medical insurance coverage for themselves and/or the retiree's eligible dependent(s) due to other group coverage. (Note: A retiree who is **not** covered by another group medical plan, may not waive coverage, but may drop/cancel coverage, which results in a forfeiture of future enrollment rights into a County-offered Retiree medical plan.)

The option to waive coverage is a **one-time option** available only at the time of retirement or upon initial eligibility for newly eligible dependents. A retiree who waives coverage has no annual enrollment rights.

A retiree who waives medical coverage will be allowed to re-enroll themselves and any eligible dependent(s), upon the following conditions being met:

1. The retiree must re-enroll **within 31 days** of the loss of other group insurance coverage and provide the County with evidence of the loss of coverage. Failure to provide proof of coverage loss will result in denial of enrollment and the retiree will forfeit future enrollment rights and County contributions, if applicable, towards the retiree medical plans.
2. At the latest, the retiree must re-enroll **no later than 60 days after the effective date of the retiree's Medicare eligibility for coverage**. A retiree, and any eligible dependent also being enrolled who is eligible for Medicare, must have Medicare Parts A and B and must provide proof of this Medicare coverage to the County of Sonoma's Human Resources Benefits Unit. Medicare assignment of benefits to County retiree medical plans is required for some County medical plans, such as Kaiser Permanente Senior Advantage and UHC AARP medical plan.
3. The retiree's re-enrollment is required in order for any eligible dependent(s) to be enrolled in a County offered medical plan, except as follows in #4 below.
4. The retiree may add an eligible dependent spouse or domestic partner at a later time provided the eligible dependent is enrolled in other group coverage since the date of retirement date.
5. Eligible dependent children must be enrolled at the time the retiree elects coverage.

By signing below, I acknowledge that:

- I have read and understand the information above.
- I have been given the opportunity to enroll or waive coverage for myself and my eligible dependents in a County-offered medical plan pursuant to the eligibility criteria outlined in the Salary Resolution and the health plan's document.
- I understand that failure to notify and provide proof of loss of other group coverage within 31 days, failure to obtain, assign benefits to a County retiree medical plan if applicable and provide proof of Medicare Parts A and B within 60 days of Medicare eligibility and/or failure to pay premiums will result in termination of County retiree medical benefits and forfeiture of County contribution, if applicable, to County retiree medical plans.
- I understand that I am required to notify County of Sonoma Human Resources Benefits if my eligibility or my dependent's eligibility for Medicare Parts A and B changes.

If I become eligible to make a change during the plan year, I must request the change within 31 days of the event.

Retiree/Survivor Signature _____ Date _____

SECTION 10: Retiree Declaration of Accurate Information, Retiree Responsibilities, and Authorization to Enroll and Payment of Premiums through Retiree Warrant Signature

Retiree signature and date is required for all new benefit enrollments and changes.

I declare under penalty of perjury that:

- I agree to comply with the terms of the benefits group contracts in which I am enrolled;
- I authorize the Sonoma County Employees' Retirement Association (SCERA) to withhold all insurance premiums in excess of any County contribution for the benefits requested in accordance with the applicable Board of Supervisor's Resolution;
- I certify that all eligible dependents listed meet the medical plan's eligibility requirements;
- I will complete a new Retiree Benefits Enrollment/Change Form for myself and for my eligible dependents **within 31 days** of a change in benefit eligibility and that my failure to provide timely enrollment forms will result in denial for enrollment and loss of any future County plan contribution to a County retiree medical plan;
- I will inform the Human Resources Benefits Unit when I or any of my dependents become Medicare eligible;
- I understand that I, and my eligible enrolled dependents, will be required to obtain both Medicare Parts A and B and provide proof of such eligibility **within 60 days** from date of Medicare eligibility;
- I understand that if I and/or any of my eligible dependents fail to provide proof of enrollment in Medicare Parts A and B, fail to assign Medicare benefits to County retiree medical plans or fail to notify the County of a change in Medicare eligibility, it will result in the loss of my County retiree medical plan and therefore will be a forfeiture of any future County plan contribution, if applicable, to a County retiree medical plan or it will result in additional premiums owed on some plans;
- I certify that the information provided on this form is complete, true, and correct to the best of my knowledge; and
- I authorize SCERA to release to the County of Sonoma all information reasonably necessary to evaluate or administer my retiree health benefits.

Retiree/Survivor Signature _____ Date _____

Ready to submit your forms?

You have several options to submit your enrollment/change forms.

Email: benefits@sonoma-county.org

Fax: (707) 565-1139

Mail To: County of Sonoma
c/o HR Benefits Unit
575 Administration Dr, Suite 116B
Santa Rosa, CA 95403

In Person: 575 Administration Dr., Suite 117C

After Hours Drop Off: Place in the locked tan drop box outside the North entrance of 575 Administration Drive in Santa Rosa (main entrance by Human Resources)