LACERA

Medical Plan

New Enrollment/Change/Cancellation

To assist you in completing this form, a SAMPLE has been provided on www.lacera.com, under the Retiree Healthcare tab.

Please be sure to fill in ALL required areas and provide ALL required/necessary documents. Any missing information will cause a delay in processing this form.

Section 1: Membership Information

Fill in the personal information requested.

Section 2: Reason

Check the box next to the reason you are completing this form (i.e., new enrollment, change medical plan, change of address, etc.).

Section 3: Family Information

Fill in the information requested for yourself and any eligible dependents you want to cover.

Print your name and Social Security number at the top of pages 2 – 6.

Section 4: Medical Plan Information

Check one plan for yourself and one plan for your eligible dependents. Provide additional information, if requested.

Section 5: Read, Understand, Sign and Date Health Plan Authorization

Section 6: Read, Understand, Sign and Date LACERA Authorization

Carefully read, sign and date the appropriate health plan arbitration language. Your completed form must be physically signed. No electronic signatures are accepted at this time.

To submit your form and documentation:

- Scan and upload your forms to My LACERA via lacera.com (recommended). This is the fastest method of submission, and you will receive a confirmation of receipt. OR
- Mail your forms to LACERA, P.O. Box 7060, Pasadena, CA 91109-7060. OR
- Fax your forms to 626-564-6155. OR
- Drop off your forms in the secure dropbox outside our Member Service Center at 300 N. Lake, Pasadena, CA 91101.

Remember to keep the bottom copy for your records.

LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website, www.lacera.com.

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LACERA

Los Angeles County Employees Retirement Association
PO Box 7060 • Pasadena, CA 91109-7060 • www.lacera.com

Please check one of the following boxes:

MEDICAL PLAN

☐ New Enrollment ☐ Change ☐ Cancellation

(FOR LACERA USE ONLY)

Retirement Date_____
☐ SCD ☐ Tier 1
☐ NSCD ☐ Tier 2 ☐ PPA Initials
Input Date _____ Initials _____

Effective Date _____
Years of Service _____
Email/Fax Date _____

Deduction Code
Current Med: _____ AME Entry Date: _____
New Med: _____ Emp Site Entry Date: _____
Premium Med: $ _____

Section 1: LACERA MEMBERSHIP INFORMATION

Please check one:
Completed by ☐ Retiree ☐ Survivor ☐ COBRA Participant COBRA Period (months) ☐ 18 ☐ 29 ☐ 36

Last Name (Print)	First Name (Print)	M.I.	Social Security Number

Street Address	Apt.	Date of Birth	Sex: ☐ Male ☐ Female

City	State	ZIP Code

Email Address	Contact Phone Number ( )	Alternate Phone Number ( )

Marital Status (check one) ☐ Single

☐ Married, date of marriage _____ ☐ Divorced, date of divorce/legal separation _____

☐ Widowed, date of death _____ ☐ Domestic Partner, date of registration _____

☐ Domestic Partnership Terminated, date of termination _____

Current Medical Plan Coverage is (write in the full name of plan): _____

Other Medical Plan Coverage: Please provide the name and policy number of any other medical plan that covers you or your dependents.

Name: _____ Policy No.: _____

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Puerto Rican
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Cuban
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Chinese
☐ Japanese
☐ Other Asian
☐ Vietnamese
☐ Asian Indian
☐ Filipino
☐ Korean
☐ Other Pacific Islander
☐ White
☐ Black or African American
☐ Guamanian or Chamorro
☐ Native Hawaiian
☐ Samoan
☐ **I choose not to answer**

CONTINUE

Last Name (Print) First Name (Print) M.I. Social Security Number

Section 2: REASON

☐ **New enrollment** (Go to Sections 3 and 4)

☐ **Moving out of service area** of Kaiser Permanente, Kaiser Permanente Senior Advantage, Kaiser Permanente CO, Kaiser Permanente HI, Kaiser Permanente GA, Kaiser Permanente OR, Kaiser Permanente WA, UnitedHealthcare, UnitedHealthcare Medicare Advantage, Cigna, Cigna with Preferred Rx, Anthem Blue Cross Prudent Buyer Plan, SCAN Health Plan, SCAN Desert Health Plan, and SCAN Health Plan Nevada.

☐ **Change medical plan** (Go to Sections 3 and 4)

☐ **Cancel medical coverage** (Go to Section 3)

☐ **Add family member** (Go to Sections 3 and 4)

☐ **Delete family member** (Go to Sections 3 and 4)

☐ **Name change:** Former Name _____ (write new name in Section 1)

☐ **Address change:** Former Address _____ (write new address in Section 1)

☐ **Re-enrollment for surviving spouse/domestic partner and/or dependent children:**

Name of Deceased Retiree: _____Social Security Number _____

☐ **Other:** Explain _____

CONTINUE

Last Name (Print)	First Name (Print)	M.I.	Social Security Number

SECTION 3: FAMILY INFORMATION

Relationship	Last Name	First Name	M.I.	SSN	Date of Birth	Sex (M/F)	Medicare Coverage	Medical Coverage
Retiree							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Survivor							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Spouse*							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Domestic Partner*							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: ________	☐ Yes ☐ No

* To cover your eligible spouse/dependent children/domestic partner, provide a copy of your marriage certificate/birth certificate/Certificate of Registration of Domestic Partnership from the State of California, and a signed Attestation Form (contact LACERA for this form). If originals are submitted, they will be returned to you after verification. (NOTE: For enrollees in the Kaiser - Washington Out-of-State Plan, Washington State Registered Domestic Partners are treated the same as a spouse.)

** Please attach a copy of legal document for your adopted children. Eligible dependent children are eligible for coverage up to the age of 26 regardless of marital status, student status, or eligibility for coverage under another plan.

CONTINUE

Last Name (Print) First Name (Print) M.I. Social Security Number

SECTION 4: MEDICAL PLAN INFORMATION Please check only one plan which will cover you and your dependent(s):

HMO PLANS	MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS You must be enrolled in Medicare Parts A and B	INDEMNITY PLANS Benefits may differ by state
☐ **Kaiser Permanente**[1] State of residence: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA[3] Benefits and premiums may differ by state ☐ Myself ☐ Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	☐ **Kaiser Permanente Senior Advantage**[1, 2] State of residence: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA[3] Benefits and premiums may differ by state ☐ Myself ☐ Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	☐ **Anthem Blue Cross Plan I** ☐ Myself ☐ Dependent(s) ☐ **Anthem Blue Cross Plan II** ☐ Myself ☐ Dependent(s) ☐ **Anthem Blue Cross Prudent Buyer Plan** ☐ Myself ☐ Dependent(s)
☐ **Cigna Network Model Plan**[1] ☐ Medical Group Healthplan ☐ Private Practice Network ☐ Myself ☐ Dependent(s) List medical group or physician name/ number for yourself and each dependent: _____	☐ **Cigna Preferred with Rx** *(available in Maricopa County and Apache Junction, Pinal County, Arizona only)*[1, 2] ☐ Medical Group Healthplan ☐ Private Practice Network ☐ Myself ☐ Dependent(s) List medical group or physician name/ number for yourself and each dependent: _____	**MEDICARE SUPPLEMENT PLAN** You must be enrolled in Medicare Parts A and B ☐ **Anthem Blue Cross Plan III**[2] ☐ Myself ☐ Dependent(s)
☐ **UnitedHealthcare**[1] ☐ Myself ☐ Dependent(s) If you have been a UnitedHealthcare member, list your member number: _____ List primary care physician's name, number, and medical group: _____ City: _____ Are you an existing patient? ☐ Yes ☐ No	☐ **UnitedHealthcare Medicare Advantage**[1, 2] ☐ Myself ☐ Dependent(s) If you have been a UnitedHealthcare Medicare Advantage member, list your member number: _____ List name of medical group or Independent Practice Association (IPA): _____ City: _____ Are you an existing patient? ☐ Yes ☐ No ☐ **SCAN Health Plan**[1, 2] ☐ Myself ☐ Dependent(s) ☐ AZ ☐ CA ☐ NV	*Note: If you switch between any of the Anthem Blue Cross plans, the plan lifetime maximum will carry forward from one plan to another. For example, if you change from the Anthem Blue Cross Prudent Buyer Plan to Plan I or II, your accumulated expenses from the Prudent Buyer Plan will count toward your lifetime maximum for the new plan you've chosen.*

[1] Subject to service area availability.

[2] Members enrolled in both Medicare Part A and Part B, who are enrolling in a Medicare Advantage Prescription Drug (MAPD) plan (except those enrolling in Anthem Blue Cross III) must also complete an MAPD Election form in order to assign their Medicare benefits. LACERA will provide the necessary MAPD election form. Each individual enrolling in a MAPD Plan and Anthem Blue Cross III must attach a photocopy of his/her Medicare card. Please do not send the original to LACERA.

[3] Kaiser Foundation Health Plan of Washington - 1300 SW 27th Street, Renton, WA 98057

CONTINUE AND SIGN

REMEMBER: SIGN IN *TWO* PLACES:

1. **You must provide your signature in Section 5:** Binding Arbitration Agreement.
   - If enrolling in a UnitedHealthcare, Cigna HealthCare, Anthem Blue Cross or SCAN Health Plan, **sign and date at the top of Page 5.**
   - If enrolling in a Kaiser Foundation Health Plan, **sign and date at the bottom of Page 5.**
2. **You must also provide your signature on Page 6** below the dotted lines.

IMPORTANT NOTE: If you submit this form without signing the appropriate arbitration language or affixing your signature on Page 6, this form will be considered incomplete and the start of your coverage may be delayed.

(CONTINUE NEXT PAGE)

Last Name (Print) First Name (Print) M.I. Social Security Number

SECTION 5: READ AND UNDERSTAND/AUTHORIZATION

Arbitration Agreement for UnitedHealthCare (UHC), Cigna HealthCare, Anthem Blue Cross of California and SCAN Health Plan:

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, 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 in the health plan's coverage document, which is available for my review.

Signed _____ Date _____ 20_____

Arbitration Agreement for Kaiser Foundation Health Plan - California

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.

Signed _____ Date _____ 20_____

Arbitration Agreement for Kaiser Foundation Health Plan - Hawaii

Except as provided in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement, any and all claims or disputes shall be resolved by binding arbitration. I acknowledge that I have read and understood the information in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement (attached). I, on behalf of myself, all applicants, and all family members, hereby agree to binding arbitration and give up our constitutional rights to a jury or court trial.

Signed _____ Date _____ 20_____

Top Copy - Medical Carrier
Bottom Copy - Subscriber

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CONTINUE

IMPORTANT REMINDER:

Carefully read, sign and date the LACERA authorization on Page 6, below the dotted lines. Your completed form must be physically signed. No electronic signatures are accepted at this time.

If we receive the form with missing signatures, this form will be considered incomplete and the start of your coverage may be delayed.

(CONTINUE NEXT PAGE)

Last Name (Print) First Name (Print) M.I. Social Security Number

SECTION 6: READ AND UNDERSTAND/AUTHORIZATION (LACERA)

I understand that if I elect either Cigna Medicare Select Plus Rx (Phoenix, AZ only), Kaiser Permanente Senior Advantage, UnitedHealthcare Medicare Advantage or a SCAN Health Plan, this automatically disenrolls me from any other Medicare-contracting pre-paid health care plan in which I was enrolled. Additionally, I may voluntarily request disenrollment from any of the Medicare Advantage-Prescription Drug HMOs at any time. I may disenroll by submitting written notice directly to the Medicare Advantage-Prescription Drug HMO I am enrolled in, or through any Social Security Administration office.

I hereby enroll for the Group Health Coverage indicated in Section 4 of this form. I authorize the Los Angeles County Employees Retirement Association (LACERA) to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the company chosen by me. I understand the LACERA Board of Retirement reserves the right to amend, revise, or discontinue these plans and programs at any time.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO REPORT ANY CHANGE IN THE ELIGIBILITY OF MYSELF AND/OR MY DEPENDENTS TO LACERA IN WRITING WITHIN 30 DAYS OF THE CHANGE.

I also understand that all of the benefits of these plans are coordinated with benefits provided by any other group, hospital or medical benefit or service plan, including Medicare.

I hereby authorize any physician, surgeon, practitioner or other person, any hospital including any medical service organization, or insurance company to release to each other any medical or other information, including benefits paid or payable, on any sickness or illness that I now have or may sustain. This authorization will be valid for a period not to exceed 30 months past the date of my signature below.

Please carefully read the paragraphs above; then sign below to indicate your understanding and agreement.

Signed _____ Date _____ 20_____

*Your signature or signature of guardian, conservator or power of attorney**

Your Spouse's/Domestic Partner's Signature _____ Date _____ 20_____

*Your spouse's/domestic partner's signature or signature of guardian, conservator or power of attorney**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

* If this is submitted by a guardian or conservator, please attach the legal document establishing guardianship, conservatorship or the power of attorney to this form. Keep the last copy for your records. Return the top copy along with any other required/necessary documents to LACERA.

Top Copy - Medical Carrier
Bottom Copy - Subscriber

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FOR LACERA USE ONLY

(FOR LACERA USE ONLY)

UHC/UHC MA		
Code Description	**Group #**	**Group #**
	UHC MA	**UHC**
	Check applicable box	
Member Only	☐ 004237	-
Mbr & Sp 1 MDC	☐ 004237	☐ 004238
Mbr & Sp 2 MDC	☐ 004237	-
Mbr/Sp/Ch 1 MDC	☐ 004237	☐ 004239
Mvr/Sp/Ch 2 MDC	☐ 004237	☐ 004240
Dep Child	-	☐ 147243
Commercial Mbr Only-Single	-	☐ 004241
Commercial Mbr + 1 Dep-Dual	-	☐ 004241
Commercial Mbr + Family-Family	-	☐ 004241

Kaiser Permanente (CA)		
Code Description	**Group #**	**Group #**
	Check applicable box	
Kaiser Permanente	☐101002	
Kaiser Permanente Senior Advantage		☐101002
Kaiser Permanente Out-of-State		
Kaiser Permanente Colorado	☐ 11178-005	
Kaiser Permanente Hawaii	☐ 34628-001	
Kaiser Permanente Georgia	☐ 3221-100	
Kaiser Permanente Oregon	☐ 4310-001	
Kaiser Permanente Washington	☐ 2066600	