



## Medical Plan

### New Enrollment/Change/Cancellation

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 this and all following pages.*

#### 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 and Understand/Authorization

Carefully read each paragraph. **Sign and date the form at the bottom on the lines provided and return the completed form to:**

LACERA  
P.O. Box 7060  
Pasadena, CA 91109-7060

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](http://www.lacera.com).*

## **Statement of Non-Discrimination**

The LACERA-administered Retiree Healthcare Benefits Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

LACERA-administered Retiree Healthcare Benefits Program cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

LACERA-administered Retiree Healthcare Benefits Program

遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Please check one of the following boxes:

# MEDICAL PLAN

**New Enrollment**  **Change**  **Cancellation**

<b>(FOR LACERA USE ONLY)</b>		<b>EFFECTIVE DATE</b> _____	<b>Deduction Code</b>
Retirement Date _____		Years of Service _____	Current Med: _____
<input type="checkbox"/> SCD	<input type="checkbox"/> Tier 1	Fax Date _____	Input Date _____
<input type="checkbox"/> NSCD	<input type="checkbox"/> Tier 2	<input type="checkbox"/> PPA Initials	Form # _____
		Initials _____	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: <input type="checkbox"/> Male <input type="checkbox"/> Female
City			State		ZIP Code	
Email Address			Contact Phone Number ( )		Alternate Phone Number ( )	
Marital Status (check one) <input type="checkbox"/> Single						
<input type="checkbox"/> Married, date of marriage _____ <input type="checkbox"/> Divorced, date of divorce/legal separation _____						
<input type="checkbox"/> Widowed, date of death _____ <input type="checkbox"/> Domestic Partner, date of registration _____						
<input type="checkbox"/> 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.: _____						

## Section 2: REASON

- |   |   |
|---|---|
| <input type="checkbox"/> <b>New enrollment</b> (Go to Sections 3 and 4)   | <input type="checkbox"/> <b>Change medical plan</b> (Go to Sections 3 and 4)  |
| <input type="checkbox"/> <b>Moving out of service area</b> 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-HealthSpring with Preferred Rx, Anthem Blue Cross Prudent Buyer Plan or SCAN Health Plan | <input type="checkbox"/> <b>Cancel medical coverage</b> (Go to Section 3)     |
| <input type="checkbox"/> <b>Name change:</b> Former Name _____ (write new name in Section 1)  | <input type="checkbox"/> <b>Add family member</b> (Go to Sections 3 and 4)    |
| <input type="checkbox"/> <b>Address change:</b> Former Address _____ (write new address in Section 1)   | <input type="checkbox"/> <b>Delete family member</b> (Go to Sections 3 and 4) |
| <input type="checkbox"/> <b>Re-enrollment for surviving spouse/domestic partner and/or dependent children:</b><br>Name of Deceased Retiree: _____ Social Security Number _____  |   |
| <input type="checkbox"/> <b>Other:</b> Explain _____  |   |



**CONTINUE**



**CONTINUE**

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

HMO PLANS	<b>MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS</b> You must be enrolled in Medicare Parts A and B	<b>INDEMNITY PLANS</b> Benefits may differ by state
<input type="checkbox"/> <b>Kaiser Permanente<sup>1</sup></b> State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR <input type="checkbox"/> WA <sup>3</sup> Benefits and premiums may differ by state <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> <b>Kaiser Permanente Senior Advantage<sup>1,2</sup></b> State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR <input type="checkbox"/> WA <sup>3</sup> Benefits and premiums may differ by state <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> <b>Anthem Blue Cross Plan I</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <hr/> <input type="checkbox"/> <b>Anthem Blue Cross Plan II</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <hr/> <input type="checkbox"/> <b>Anthem Blue Cross Prudent Buyer Plan</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> <b>Cigna Network Model Plan<sup>1</sup></b> <input type="checkbox"/> Medical Group Healthplan <input type="checkbox"/> Private Practice Network <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) List medical group or physician name/ number for yourself and each dependent: _____	<input type="checkbox"/> <b>Cigna-HealthSpring Preferred with Rx</b> <i>(available in Maricopa County and Apache Junction, Pinal County, Arizona only)<sup>1,2</sup></i> <input type="checkbox"/> Medical Group Healthplan <input type="checkbox"/> Private Practice Network <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) List medical group or physician name/ number for yourself and each dependent: _____	<b>MEDICARE SUPPLEMENT PLAN</b> You must be enrolled in Medicare Parts A and B <input type="checkbox"/> <b>Anthem Blue Cross Plan III<sup>2</sup></b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> <b>UnitedHealthcare<sup>1</sup></b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a UnitedHealthcare member, list your member number: _____ List primary care physician's name, number, and medical group: _____ City: _____	<input type="checkbox"/> <b>UnitedHealthcare Medicare Advantage<sup>1,2</sup></b> <input type="checkbox"/> Myself <input type="checkbox"/> 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: _____ <hr/> <input type="checkbox"/> <b>SCAN Health Plan<sup>1,2</sup></b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)	<p><i>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.</i></p>

<sup>1</sup> Subject to service area availability.

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

<sup>3</sup> Kaiser Foundation Health Plan of Washington - 601 Union St. Suite 3100, Seattle, WA 98101

# 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 at the top of Page 5.**
  - If enrolling in a Kaiser Foundation Health Plan, **sign at the middle of Page 5.**
2. Lastly, you **must** also provide your signature at the bottom of Page 5, below the dotted lines.



**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**

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\_\_\_\_\_

I understand that if I elect either Cigna Medicare Select Plus Rx (Phoenix, AZ only), Kaiser Permanente Senior Advantage, UnitedHealthcare Medicare Advantage or 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.

**FOR LACERA USE ONLY**

(FOR LACERA USE ONLY)

**UHC/UHC MA**

Code Description	Group #	Group #
	<b>UHC MA</b>	<b>UHC</b>
Check applicable box		
Member Only	<input type="checkbox"/> 004237	-
Mbr & Sp 1 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004238
Mbr & Sp 2 MDC	<input type="checkbox"/> 004237	-
Mbr/Sp/Ch 1 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004239
Mvr/Sp/Ch 2 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004240
Dep Child	-	<input type="checkbox"/> 147243
Commercial Mbr Only-Single	-	<input type="checkbox"/> 004241
Commercial Mbr + 1 Dep-Dual	-	<input type="checkbox"/> 004241
Commercial Mbr + Family-Family	-	<input type="checkbox"/> 004241

**Kaiser Permanente (CA)**

Code Description	Group #	Group #
Check applicable box		
Kaiser Permanente	<input type="checkbox"/> 101002	
Kaiser Permanente Senior Advantage		<input type="checkbox"/> 101002
Kaiser Permanente Out-of-State		
Kaiser Permanente Colorado	<input type="checkbox"/> 11178-001	
Kaiser Permanente Hawaii	<input type="checkbox"/> 34628-001	
Kaiser Permanente Georgia	<input type="checkbox"/> 3221-100	
Kaiser Permanente Oregon	<input type="checkbox"/> 4310-001	
Kaiser Permanente Washington	<input type="checkbox"/>	