



Alameda County Employees' Retirement Association
 475 14th Street, Suite 1000
 Oakland, CA 94612
 510-628-3000 or 1-800- 838-1932, Press 1
www.acera.org

Please print or type

ACERA Medical Plan Enrollment Form

Check the reason for completing this form:

- Retirement
- Open Enrollment
- Loss of Coverage
- COBRA

SECTION 1: MEMBER ENROLLMENT INFORMATION

Name: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Telephone No.: _____

I am enrolled (or in the process of enrolling) in Medicare:

No Yes (If yes, you must enroll in an ACERA-sponsored Medicare plan and fill-in your Medicare information below.)

Medicare No.: _____ Part A Effective Date: _____ Part B Effective Date: _____

My current ACERA coverage is: No Coverage Self Coverage Self + 1 Coverage Family Coverage

SECTION 2: TYPE OF CHANGE REQUESTED

- Forms must be received by ACERA by the applicable deadline.
- If you are adding, changing, or cancelling dependent coverage, you must complete the *Dependent's Section(s) on the next page.*

New Enrollment **Circle coverage type** Self Coverage Self + 1 Coverage Family Coverage

Change Medical Plan **Circle coverage type** Self Coverage Self + 1 Coverage Family Coverage

Cancel Coverage

SECTION 3: SELECT YOUR MEDICAL PLAN

- For Anthem Blue Cross HMO, PacifiCare SignatureValue (HMO), and the MedicareComplete® Retiree Plan, you must also select a PCP and Medical Group; otherwise the provider will select one for you. Note: You must live within 30 miles of the Medical Group.

NON-MEDICARE PLANS (For non-Medicare-eligible individuals)

Anthem Blue Cross HMO Primary Care Physician/Medical Group: _____

Kaiser Permanente HMO

PacifiCare SignatureValue (HMO) Primary Care Physician/Medical Group: _____

UnitedHealthcare Choice Plus (PPO)

MEDICARE PLANS (For Medicare-eligible individuals; must be enrolled in Medicare A & B; Medicare Part D is included in the Plan)

MEDICARE ADVANTAGE PLANS*** (SELECTED CALIFORNIA AREAS ONLY)

***An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

Kaiser Permanente Senior Advantage

MedicareComplete® Retiree Plan Primary Care Provider/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

UnitedHealthcare Retiree Senior Supplement Plan

SECTION 4: AUTHORIZATION AND SIGNATURE

- I AGREE TO HAVE MY RETIREMENT ALLOWANCE REDUCED BY THE AMOUNT NEEDED TO PAY MY SHARE AND MY SPOUSE/DOMESTIC PARTNER/DEPENDENT SHARE OF THE COST FOR THE HEALTH PLAN, AS INDICATED ABOVE. I ALSO AUTHORIZE THE PLAN OR CARE PROVIDER TO RELEASE ANY OR ALL MEDICAL INFORMATION FOR MYSELF OR COVERED FAMILY MEMBERS WHEN INFORMATION IS NEEDED TO PROCESS MEDICAL PLAN CLAIMS.
- I UNDERSTAND THAT THE RETIREMENT BOARD RESERVES THE RIGHT TO MODIFY OR CANCEL MEMBER HEALTH PLAN COVERAGE OR THE MONTHLY MEDICAL ALLOWANCES TOWARD THE COVERAGE. I UNDERSTAND THAT THE BENEFITS OF THE PLAN I CHOOSE ARE COORDINATED WITH THOSE PROVIDED UNDER ANY OTHER GROUP HOSPITAL, MEDICAL BENEFIT, OR SERVICE PLAN.
- I UNDERSTAND THAT I AM RESPONSIBLE FOR A GREATER PORTION OF MY MEDICAL COSTS WHEN I USE A NON-PARTICIPATING PROVIDER. I ELECT TO BE COVERED UNDER THE OPTION I HAVE CHECKED ABOVE, UNTIL I REVOKE THIS CHOICE IN WRITING. I UNDERSTAND THE PROVISIONS OF THE CHOICE I HAVE SELECTED.

SIGNATURE: _____ DATE: _____

MEMBER NAME: _____ SOCIAL SECURITY NO.: _____

SECTION 5: DEPENDENT INFORMATION

- You and your dependent **must be enrolled in the same plan.** For example, if you (the member) are enrolled in a Kaiser plan, your dependent must also be enrolled in a Kaiser plan. Attach an additional form if enrolling more than two dependents.

DEPENDENT #1 ENROLLMENT INFORMATION

New Enrollment Change Medical Plan Cancel Coverage

Name: _____ Social Security No.: _____

Date of Birth: _____ Gender: Male Female Relationship: _____

Dependent is a full-time student between ages 19 and 24; complete an ACERA Verification of Enrollment Status Form. Dependent is disabled

Dependent is enrolled (or in the process of enrolling) in Medicare: No Yes If yes, dependent must enroll in an ACERA-sponsored Medicare plan.

Medicare No.: _____ Part A Effective Date: _____ Part B Effective Date: _____

SELECT DEPENDENT MEDICAL PLAN

NON-MEDICARE PLANS (For Non-Medicare-eligible individuals)

Anthem Blue Cross HMO Primary Care Physician/Medical Group: _____

Kaiser Permanente HMO

PacifiCare SignatureValue (HMO) Primary Care Physician/Medical Group: _____

UnitedHealthcare Choice Plus (PPO)

MEDICARE PLANS (For Medicare-eligible individuals; must be enrolled in Medicare A & B; Medicare Part D is included in the Plan)

MEDICARE ADVANTAGE PLANS*** (SELECTED CALIFORNIA AREAS ONLY)

***An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

Kaiser Permanente Senior Advantage

MedicareComplete® Retiree Plan Primary Care Physician/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

UnitedHealthcare Retiree Senior Supplement Plan

DEPENDENT #2 ENROLLMENT INFORMATION

New Enrollment Change Medical Plan Cancel Coverage

Name: _____ Social Security No.: _____

Date of Birth: _____ Gender: Male Female Relationship: _____

Dependent is a full-time student between ages 19 and 24; complete an ACERA Verification of Status Enrollment Form. Dependent is disabled

Dependent is enrolled (or in the process of enrolling) in Medicare: No Yes If yes, dependent must enroll in an ACERA-sponsored Medicare plan.

Medicare No.: _____ Part A Effective Date: _____ Part B Effective Date: _____

SELECT DEPENDENT MEDICAL PLAN

NON-MEDICARE MEDICARE PLANS (For Non-Medicare-eligible individuals)

Anthem Blue Cross HMO Primary Care Physician/Medical Group: _____

Kaiser Permanente HMO

PacifiCare SignatureValue (HMO) Primary Care Physician/Medical Group: _____

UnitedHealthcare Choice Plus (PPO)

MEDICARE PLANS (For Medicare-eligible individuals; must be enrolled in Medicare A & B; Medicare Part D is included in the Plan)

MEDICARE ADVANTAGE PLANS*** (SELECTED CALIFORNIA AREAS ONLY)

***An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

Kaiser Permanente Senior Advantage

MedicareComplete® Retiree Plan Primary Care Physician/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

UnitedHealthcare Retiree Senior Supplement Plan

NAME: _____ SOCIAL SECURITY NO.: _____

SECTION 6: PROVIDER ARBITRATION AGREEMENTS

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 ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT.

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 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 AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE 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 OR ANY OTHER ISSUES RELATED TO THE PLAN.

Signature (Required): _____ Date: _____

Kaiser Foundation Health Plan Arbitration Agreement: 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, relatives, 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 (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.

Signature: _____ Date: _____

PACIFICARE (HMO AND PPO) BINDING ARBITRATION: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND 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 CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES 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 THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES 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.

Signature: _____ Date: _____

FOR ACERA USE ONLY

Input by: _____	Date: _____	Verified by: _____	Date: _____
Group Number: _____	Effective Date: _____		



Alameda County Employees' Retirement Association
475 14th Street, Suite 1000
Oakland, CA 94612
1-800-838-1932
www.acera.org

ACERA Medical Plan Enrollment Form Instructions

SECTION 1: MEMBER ENROLLMENT INFORMATION

- Fill in your name, Social Security number, and demographic information.
- If enrolled, or in the process of enrolling, in Medicare, check the appropriate box. Also, provide a copy of your Medicare card or Letter of Verification from the Social Security Administration.
- Provide your current coverage information, if you are currently enrolled. If unsure, please leave blank.

SECTION 2: TYPE OF CHANGE REQUESTED

- Check "New Enrollment," and circle coverage type, if you currently have no health coverage through ACERA. This will let us know if you are covering only yourself or any eligible dependents.
- Check "Change Medical plan" and circle coverage type, if you are changing coverage, adding and/or dropping dependents, changing providers, or changing coverage within the same provider. This will let us know if you are covering only yourself or any dependents.
- Check "Cancel Coverage," if dropping your medical plan. Note: This will also cancel dependent coverage.

SECTION 3: SELECT YOUR MEDICAL PLAN

- Review the current *ACERA Enrollment and Health Plan Brochure* before selecting a medical plan. You and your dependents must be enrolled under the same plan provider.
- You must be non-Medicare eligible to enroll in a Non-Medicare Plan.
- A Primary Care Physician and Medical Group must be selected upon enrollment in Anthem Blue Cross HMO, PacifiCare SignatureValue (HMO), or MedicareComplete® Retiree Plan.***
- You must be enrolled in Medicare A & B or in the process of enrolling to select a Medicare Plan.
- A Medicare Advantage Plan form or disenrollment form must be completed upon enrolling or canceling coverage with Kaiser Senior Advantage or MedicareComplete® Retiree Plan. Call ACERA at 1-800-838-1932 to obtain the required form.

***A provider directory can be obtained by calling the provider's customer service number or through its website. Contact information is listed on the back of the *ACERA Enrollment and Health Plan Brochure*.

- Carefully read each bullet point. Sign and date the form. Keep the yellow copy for your records. Mail the white copy to ACERA.
- If a Durable Power of Attorney (POA) or Legal Guardian/Conservatorship helped complete this form, he/she must sign it and attach a copy of the applicable court order or POA document establishing authority to act on your behalf, if not already on file with ACERA.

SECTION 5: DEPENDENT ENROLLMENT INFORMATION

- Review the *ACERA Enrollment and Health Plan Brochure* for the definition of a dependent and requirements for adding a dependent to your coverage.
- List the name, Social Security number, relationship, and birth date of any dependents you are enrolling.
- Complete and attach an *ACERA Verification of Enrollment Status Form* if your dependent is age 19 – 24 and a full-time student.
- Attach supporting documents, if your dependent is disabled.
- Your dependent must enroll in a Medicare Plan, if he/she is enrolled or in the process of enrolling in Medicare.
- Check the appropriate box and provide a copy of his/her Medicare card or Letter of Verification from the Social Security Administration.

SELECT DEPENDENT'S MEDICAL PLAN

- You and your dependents must be enrolled under the same carrier.
- Dependents must be non-Medicare eligible to enroll in a non-Medicare Plan.
- A PCP and Medical Group must be selected upon enrolling your dependent in Anthem Blue Cross HMO, PacifiCare SignatureValue (HMO), or MedicareComplete® Retiree Plan. ***
- Dependents must be enrolled in Medicare A & B or in the process of enrolling to select a Medicare Plan.
- Dependents upon enrolling or canceling coverage with Kaiser Senior Advantage or MedicareComplete® Retiree Plan must complete a Medicare Advantage Plan form or disenrollment form. To obtain the required form, call ACERA at 1-800-838-1932.

SECTION 6: PROVIDER ARBITRATION AGREEMENTS

- Carefully read the appropriate provider arbitration agreement. Sign and date under the provider chosen.

Turn the page to make changes ►

SECTION 4: AUTHORIZATION AND SIGNATURE