



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 Retiree Enrollment Guide* 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, UnitedHealthcare SignatureValue (HMO), or UnitedHealthcare Group Medicare Advantage 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 UnitedHealthcare Group Medicare Advantage 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 Retiree Enrollment Guide*.

SECTION 4: AUTHORIZATION AND SIGNATURE

- Carefully read each bullet point. Sign and date the form. Keep a copy for your records. Mail the completed form 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 section titled, "Enrolling Your Eligible Dependents" in the *ACERA Retiree Enrollment Guide* for the definition of a dependent and the new 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 Affidavit of Dependent Eligibility* if your dependent is age 19-26.
- 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, UnitedHealthcare SignatureValue (HMO), or UnitedHealthcare Group Medicare Advantage 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 UnitedHealthcare Group Medicare Advantage 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 ►



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ACERA Medical Plan Enrollment Form

Check the reason for completing this form:

- Retirement
- Open Enrollment
- Loss of Coverage
- COBRA

Event Date _____

Please print or type

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 UnitedHealthcare SignatureValue (HMO), and the UnitedHealthcare Group Medicare Advantage Plan, you must also select a PCP and Medical Group; otherwise the provider will select one for you. Note: You must live within a specific set of miles of the Medical Group.

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

- Kaiser Permanente HMO
- UnitedHealthcare 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
- UnitedHealthcare Group Medicare Advantage Plan Primary Care Provider/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

- UnitedHealthcare 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 between ages 19 and 26; complete an ACERA Affidavit of Dependent Eligibility. 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)

- Kaiser Permanente HMO
- UnitedHealthcare 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
- UnitedHealthcare Group Medicare Advantage Plan Primary Care Provider/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

- UnitedHealthcare 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 between ages 19 and 26; complete an ACERA Affidavit of Dependent Eligibility. 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)

- Kaiser Permanente HMO
- UnitedHealthcare 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
- UnitedHealthcare Group Medicare Advantage Plan Primary Care Provider/Medical Group: _____

SUPPLEMENTAL PLAN (NATIONWIDE COVERAGE)

- UnitedHealthcare Senior Supplement Plan

MEMBER NAME: _____

SOCIAL SECURITY NO.: _____

SECTION 6: PROVIDER ARBITRATION AGREEMENTS

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), 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:** _____

Signature required for all Kaiser Permanente plans.

UNITEDHEALTHCARE (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

Group Number:

Effective Date:

Member/Dependent: Keep a copy for your records.

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