ACERA Medical Plan Enrollment Form Instructions

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

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.
- **Retirees only** should provide their current coverage information if you are currently enrolled. If unsure, please leave blank.

SECTION 2: TYPE OF CHANGE REQUESTED

- For a "New Enrollment" check the box for a 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.
- For a "Change Medical Plan" check the box for a coverage type if you are changing coverage, dependents, carriers, or coverage within the same carrier. 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 carrier.
- 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 SignatureValue Advantage HMO.
- 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 Permanente Senior Advantage. Call ACERA at 1-800-838-1932 to obtain the required form.
- Call 1-888-427-8730 (Medicare) or 1-844-353-0770 (Non-Medicare) to enroll in a plan through Via Benefits.

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, then 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:

(A) 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, deleting, or retaining a dependent to/from your coverage.
- Select a box for New Enrollment, Change Medical Plan, or Cancel 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* form if your dependent's age is 19 to age 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.

(B) SELECT DEPENDENT 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 Primary Care Physician and Medical Group must be selected upon enrolling your dependent in UnitedHealthcare SignatureValue HMO or SignatureValue Advantage HMO. ***

  *** *A provider directory may 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.*

- Dependents must be enrolled in Medicare Parts A & B or in the process of enrolling to select a Medicare Plan.
- Dependents upon enrolling or canceling coverage with Kaiser Permanente Senior Advantage must complete a Medicare Advantage Plan form or disenrollment form. To obtain the required form, call ACERA at 1-800-838-1932.

SECTION 6: CARRIER ARBITRATION AGREEMENTS

- Carefully read, sign and date the appropriate carrier arbitration agreement.

Turn the page to make changes ▶

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510-628-3000 or 1-800-838-1932, Press 1 www.acera.org

Select the reason (event) for completing this form:
☐ Moved out of Service Area ☐ Loss of Coverage ☐ Change Plans
☐ Open Enrollment ☐ COBRA (18 months, 29 months, or 36 months)
☐ Retirement Event Date: _____

Section 1: Member Enrollment Information (Please Print or Type)

Name: _____ Last 4 SSN: XXX-XX-_____

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

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

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

☐ 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: _____

(Retired Members Only) My current coverage THROUGH ACERA is: ☐ No Coverage ☐ Self Coverage ☐ Self + 1 ☐ Family

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 *Section 5: Dependent Information on the next page*.

New Enrollment → **Select ONE coverage type:** ☐ Self Coverage ☐ Self + 1 Coverage ☐ Family Coverage

Change Medical Plan → **Select ONE coverage type:** ☐ Self Coverage ☐ Self + 1 Coverage ☐ Family Coverage

Cancel Coverage → ☐

Section 3: Select Your Medical Plan

- To choose either UnitedHealthcare HMO you must select a Primary Care Physician and Medical Group or the insurance company will select one for you. Note: You must live in proximity to the Primary Care Physician.

Non-Medicare Plans (For Non-Medicare-Eligible Individuals)

☐ Kaiser Permanente HMO (#7668)

☐ UnitedHealthcare SignatureValue HMO (#149659) → Primary Care Physician/Medical Group: _____

☐ UnitedHealthcare SignatureValue **Advantage** HMO (#251928) → Primary Care Physician/Medical Group: _____
(Contact UnitedHealthcare at 1-800-624-8822 to determine what doctors and providers are included in the **Advantage** HMO.)

Medicare Advantage Plan (Selected California Areas Only)

Medicare-eligible individuals must be enrolled in Medicare Parts A & B. Medicare Part D is included in the Plan.
An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

☐ Kaiser Permanente Senior Advantage (#7668)

Section 4: Authorization And Signature

- I understand it is unlawful to knowingly (1.) provide false information to receive, reduce, or deny any benefit to myself or any person and (2.) accept and/or retain payment from a retirement system that the recipient is not entitled to.* See note on page 3
- I agree to have my retirement allowance reduced by the amount needed to pay my share and the share of my spouse/domestic partner/dependent of the cost for the health plan 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: _____ **Last 4 SSN:** XXX-XX-_____

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 Permanente plan, then your dependent must also be enrolled in a Kaiser Permanente plan. Attach an additional form if enrolling more than two dependents.

Dependent #1 Enrollment Information

☐ New Enrollment ☐ Change Medical Plan ☐ Cancel Coverage

Name: _____ Last 4 SSN: XXX-XX-_____

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

☐ Dependent over 19 to age 26; a completed ACERA Affidavit of Dependent Eligibility form is attached. ☐ Dependent is disabled

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

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

Non-Medicare Plans (For Non-Medicare-Eligible Individuals)

☐ Kaiser Permanente HMO

☐ UnitedHealthcare SignatureValue (HMO) → Primary Care Physician/Medical Group: _____

☐ UnitedHealthcare SignatureValue Advantage (HMO) → Primary Care Physician/Medical Group: _____

Medicare Advantage Plan (Selected California Areas Only)

Medicare-eligible individuals must be enrolled in Medicare Parts A & B. Medicare Part D is included in the Plan.
An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

☐ Kaiser Permanente Senior Advantage

Dependent #2 Enrollment Information

☐ New Enrollment ☐ Change Medical Plan ☐ Cancel Coverage

Name: _____ Last 4 SSN: XXX-XX-_____

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

☐ Dependent age 19 to 26; a completed ACERA Affidavit of Dependent Eligibility form is attached. ☐ 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: _____

Non-Medicare Plans (For Non-Medicare-Eligible Individuals)

☐ Kaiser Permanente HMO

☐ UnitedHealthcare SignatureValue (HMO) → Primary Care Physician/Medical Group: _____

☐ UnitedHealthcare SignatureValue Advantage (HMO) → Primary Care Physician/Medical Group: _____

Medicare Advantage Plan (Selected California Areas Only)

Medicare-eligible individuals must be enrolled in Medicare Parts A & B. Medicare Part D is included in the Plan.
An additional form is required if you are enrolling, changing, or canceling a Medicare Advantage Plan.

☐ Kaiser Permanente Senior Advantage

MEMBER NAME: _____ **Last 4 SSN:** XXX-XX-_____

Section 6: Carrier Arbitration Agreements

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.

SIGNATURE: _____ **DATE:** _____

Signature Required for Kaiser Permanente Plan

UnitedHealthcare (SV HMO and SVA HMO) 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 UnitedHealthcare of California, UnitedHealthcare 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 rights 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:** _____

Signature Required for all UnitedHealthcare Plans

Note: The County Employees' Retirement Law of 1937, as amended, provides that is unlawful to make or cause to be made, or present any knowingly false material statement or material misrepresentation, to knowingly fail to disclose a material fact, or otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit to any person. As well, it is unlawful to knowingly accept or obtain payment from a retirement system with knowledge that the recipient is not entitled to the payment and to retain the payment for personal use or benefit.

Keep a copy for your records.

FOR ACERA USE ONLY

Group Number: Effective Date:

Kaiser EU: