Medical Plan Enrollment Form

510-628-3000 • 1-800-838-1932 • **fax:** 510-268-9574 • info@acera.org

475 14th Street, Suite 1000
Oakland, CA 94612

SECTION 1 Member Information

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

Physical Home Address

City | State | ZIP

Birth Date (mm/dd/yyyy) | ☐ Male ☐ Female ☐ Unknown Gender

Personal Email Address | Phone

Please provide a copy of your Medicare card if you have a card.

Medicare Status:

☐ Not enrolled ☐ Enrolled, But Haven't Received Medicare Number Yet ☐ Enrolled

If you are enrolled in Medicare, you must enroll in an ACERA-sponsored Medicare plan in Section 5 below. If you have received your Medicare Number, you must fill-in your Medicare information below.

Enrolled in Medicare Part A (Hospital Coverage)? ☐ Yes ☐ No

Enrolled in Medicare Part B (Medical Coverage)? ☐ Yes ☐ No

Medicare No.

SECTION 2 Reason for Enrollment Form

Choose one:

☐ Enroll in Medical Coverage

☐ Change Medical Coverage

☐ Add or Drop Medical Coverage for Dependent

☐ Cancel Coverage _____

Last Day of Coverage Requested

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

SECTION 3 Enrollment Event

Choose one:

- ☐ Open Enrollment
- ☐ Retirement (enter date below)
- ☐ Moved Out of Service Area (enter date below)
- ☐ Loss of Coverage (enter date below)
- ☐ Life Event Change (marriage/divorce/death/other) (enter date below)

Retirement, Moving, Loss of Coverage, or Life Event Change Date: _____

SECTION 4 Level of Coverage

Choose one:

- ☐ Self Coverage
- ☐ Self+1 Coverage
- ☐ Family Coverage

SECTION 5 Select Your Medical Plan

Select one medical plan after reviewing the ACERA Retiree Enrollment Guide at www.acera.org/guide. Review plan costs at www.acera.org/costs.

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

- ☐ Kaiser Permanente HMO (#7668)

For UnitedHealthcare you must select a Primary Care Physician and Medical Group or the insurance company will select one for you. You must live in proximity to the Primary Care Physician you select.

- ☐ UnitedHealthcare SignatureValue HMO (#149659)

  Primary Care Physician: _____

  Medical Group: _____

- ☐ UnitedHealthcare SignatureValue **Advantage** HMO (#251928)

  Primary Care Physician: _____

  Medical Group: _____

  Visit https://alameda.welcometouhc.com/ or call 1-866-633-2474 to determine what doctors and providers are included in the Advantage HMO.

Medicare Advantage Plans

Medicare-eligible individuals must be enrolled in Medicare. Medicare Part D is included in the plan.

- ☐ Kaiser Permanente Senior Advantage (#7668)
  If you are enrolling in or canceling this plan, you must also complete the KPSA Form: www.acera.org/kpsa

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

SECTION 6

Dependent Information

- If you're adding a Domestic Partner, you must also submit an Affidavit of Domestic Partnership: www.acera.org/adp
- You must submit an Affidavit of Dependent Eligibility if enrolling a dependent other than your spouse or domestic partner who is:
  - » Ages 19-25
  - » Age 26 and older if incapable of supporting themselves due to a mental or physical disability incurred prior to age 26. www.acera.org/ade

Name	Last 4 of SSN	Birth Date	Relationship	Gender*	Medicare Eligible?
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N
			☐ Spouse ☐ Domestic Partner ☐ Dependent	☐ M ☐ F ☐ U	☐ Y ☐ N

*M=Male, F=Female, U=Unknown

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name) | Social Security Number

SECTION 7

Carrier Arbitration Agreements

You must sign the arbitration agreement corresponding to the medical carrier your are enrolling with.

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.

You must also sign Section 8 on the next page.

Signature required for all Kaiser Permanente Plans | Date (mm/dd/yyyy)

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.

You must also sign Section 8 on the next page.

Signature required for all UnitedHealthcare Plans | Date (mm/dd/yyyy)

Put your name and Last 4 of SSN or ACERA ID at the top of every page

Your Name (First Name, Middle Initial, Last Name)	Social Security Number

SECTION 8 Authorization and Signature

- 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.

Please keep a copy for your records

- 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.

Member Signature	Date (mm/dd/yyyy)

For ACERA Use Only

Group Number: Kaiser EU: 0001 Effective Date: