RETIREE BENEFITS CHANGE FORM

FORM MUST BE SUBMITTED WITHIN 31 DAYS FROM CHANGE/QUALIFYING EVENT

E-Mail: benefits@smcgov.org | **Fax#** 650-670-3080

Submit the completed form to the Benefits Office by email or fax. If you do not have access to email or fax, please contact us immediately.

MEDICARE RECIPIENTS MUST COMPLETE MEDICARE INFORMATION BELOW AND SUBMIT CHANGE FORM WITH COPY OF MEDICARE CARD IN ORDER TO MOVE INTO A MEDICARE MEDICAL PLAN

ALL CHANGES **EFFECTIVE 1st OF THE FOLLOWING MONTH** AFTER THE CHANGE FORM HAS BEEN RECEIVED

SECTION 1a. RETIREE INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL

SOCIAL SECURITY # | DATE OF BIRTH | GENDER

CELLPHONE NUMBER | HOME NUMBER | EMAIL ADDRESS

☐ **CHECK BOX IF ADDRESS HAS CHANGED**

Note: Using this form to change your address with HR-Benefits for your County health benefits does not change it with SamCERA. To change your address for retirement/pension benefit, please contact SamCERA at (650)599-1234 or samcera@samcera.org

STREET ADDRESS **NO PO BOX**

CITY | STATE | ZIP

SECTION 1b. RETIREE MEDICARE INFORMATION – COMPLETE ONLY IF ENROLLING OR CHANGING MEDICARE MEDICAL PLAN

MEDICARE NUMBER | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

SECTION 2. REASON FOR CHANGE

Effective Date of Change _____

☐ Qualified Life Event

☐ Cancel Coverage[1]

Qualified Life Event (Check One)

☐ Marriage / Domestic Partner[2]

☐ Divorce, Separation or Death

☐ Birth or Adoption[2]

☐ Change of Spouse's Employment

☐ Medicare Eligibility

☐ Sick Leave Hour Change *note in comments*

☐ Name Change/Address Change

☐ OTHER

[1]If you cancel Medical coverage; you are waiving your rights to the County's plan and will not be allowed to re-enroll. Voluntary dental and vision plans require a 12-month calendar year enrollment period from Jan-Dec and can only be terminated during Open Enrollment.

[2]Marriage Certificate, Domestic Partner Affidavit, Birth Certificate required.

SECTION 3a: COVERAGE ELECTION:

MEDICAL ☐ WAIVE[1]	☐ Alternative Health Plan	**DENTAL** ☐ WAIVE	**VISION** ☐ WAIVE
Under 65 Plans ☐ Aetna HMO ☐ Aetna AVN ☐ Aetna OAMC PPO ($200) ☐ Aetna OAMC PPO ($300) ☐ Aetna HDHP OAMC PPO ☐ Kaiser HMO ☐ Kaiser HMO HDHP ☐ Op Eng Kaiser ☐ Op Eng PPO	**Over 65 Plans** ☐ United Healthcare Medicare Advantage PPO ☐ Kaiser Sr. Advantage **Coverage Election** ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family	☐ Voluntary Cigna DHMO ☐ Voluntary Cigna DPPO **Coverage Election** ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family	☐ Voluntary Vision Service Plan **Coverage Election** ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family

RETIREE COMMENTS

SECTION 3b: ADD OR DROP DEPENDENT(S)

☐ ADD
☐ DROP

LAST NAME ____________ FIRST NAME ____________

SOCIAL SECURITY # ____________ DATE OF BIRTH ____________

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: ____________

MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

☐ ADD
☐ DROP

LAST NAME ____________ FIRST NAME ____________

SOCIAL SECURITY # ____________ DATE OF BIRTH ____________

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: ____________

MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

☐ ADD
☐ DROP

LAST NAME ____________ FIRST NAME ____________

SOCIAL SECURITY # ____________ DATE OF BIRTH ____________

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: ____________

MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)

Have you included stepchildren as dependents? ☐ NO ☐ YES - If "yes" indicate name/s: ____________

Do your stepchildren reside with you? ☐ NO ☐ YES Are they dependent upon you for support and maintenance? ☐ NO ☐ YES

SECTION 4: INDIVIDUALS WITH MEDICARE WHO CHANGED MEDICAL PLAN REQUIRED ACKNOWLEDGEMENT, INFORMATION AND SIGNATURES

By completing this enrollment application, I agree to the following:

United Healthcare/Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I

have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

United Healthcare/Kaiser Permanente serves a specific service area. If I move out of the area that United Healthcare /Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of United Healthcare/Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook or Evidence of Coverage document from United Healthcare/Kaiser Permanente when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date United Healthcare/Kaiser Permanente coverage begins, I must get all of my health care from United Healthcare/Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by United Healthcare/Kaiser Permanente and other services contained in my United Healthcare/Kaiser Permanente Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR United Healthcare/Kaiser Permanente WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with United Healthcare/Kaiser Permanente, he/she may be paid based on my enrollment in United Healthcare/Kaiser Permanente.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that United Healthcare/Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Option to request materials in language other than English (language preference) or in accessible formats.

United Healthcare: If you need information in another language or accessible format (e.g. large print or braille), contact United Healthcare at 1-800-207-1667 8 AM to 6 PM, local time, Monday through Friday.

Kaiser Permanente: Please contact Kaiser Permanente at 1-800-443-0815 if you need information in an accessible format or language other than English. Office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711.

MEDICARE MEMBER 1

Will you have other prescription drug coverage in addition to United Healthcare/Kaiser Permanente? ☐ YES ☐ NO
If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE **ID NUMBER FOR OTHER COVERAGE**

EMPLOYER OR UNION NAME **GROUP NUMBER**

NAME AND SIGNATURE **DATE**

MEDICARE MEMBER 2

Will you have other prescription drug coverage in addition to United Healthcare/Kaiser Permanente? ☐ YES ☐ NO
If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE **ID NUMBER FOR OTHER COVERAGE**

EMPLOYER OR UNION NAME **GROUP NUMBER**

NAME AND SIGNATURE **DATE**

SECTION 4a: INDIVIDUALS WITH MEDICARE WHO CHANGED MEDICAL PLAN - Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer**

What's your race? Select all that apply.

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer**

SECTION 5: FINAL SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read, understand, and agree to the terms and conditions above.

Signature of Retiree:_____ Date:

Enrollment Form Submission Instructions

1) Submit within 31 days of a qualified life event/change.
2) Submit the completed form to the Benefits Office: Email to benefits@smcgov.org | Fax at (650) 599-1573
   If you do not have access to email or fax, please contact us immediately.
3) Please print a copy of this form, sign and retain for your records.

***To help you: You can calculate your Monthly Out-of-Pocket Medical Premium:**

1. Write the total monthly premium of your medical insurance	**$**
2. Write the dollar value of your monthly sick leave hour election	**$**
3. Subtract Line 2 from Line 1. This is your monthly out-of-pocket medical premium.	**$**

For Rates and Benefits Guide, visit https://hr.smcgov.org/documents/employee-benefits-guides-rates

HR-BENEFITS USE ONLY: Effective Date Participant ID (CSM)

Division Code Change ☐ No ☐ Yes: R _____ to R _____ EFT Needed ☐ No ☐ Yes If yes, Attached? ☐ No ☐ Yes

Sick Hour Contribution Change ☐ No ☐ Yes _____ to _____ RSL Updated (Date/Initial): _____

Medicare Agreement Received ☐ No ☐ Yes ☐ N/A Alternative Health Plan Agreement Received ☐ No ☐ Yes ☐ N/A

Entered in BCC (Date/Initial) _____ Confirmed in BCC (Date/Initial) _____ Confirmation Letter Mailed (Date/Initial) _____

NOTES

_____

_____