SDCERA

SDCERA
Health Insurance Plans Enrollment form

Please complete all sections of this form. You may submit your form online by clicking on the Upload Forms button on the Medicare Plans, Non-Medicare Plans or Dental Plans pages of the SDCERA Retiree Health Insurance Program website. You may also mail or fax your forms to the SDCERA Health Plans Service Center.

SECTION 1: Member Information

First Name: MI:		Last Name:
Permanent Residence Address:		
City:	State:	ZIP:
Daytime Telephone:	Email Address:	
Date of Birth:	S.S.#	Desired Effective Date of Coverage:

SECTION 2: Plan Selection(s)

Medical Plans			
Kaiser Permanente	☐ HMO Non-Medicare	☐ Senior Advantage	
UnitedHealthcare	☐ Signature Value HMO	☐ Group Medicare Advantage	☐ Senior Supplement
Health Net	☐ HMO Non-Medicare	☐ HMO Medicare	☐ Seniority Plus
Dental Plans			
CIGNA Dental	☐ DHMO		
Delta Dental	☐ Preferred PPO		

SECTION 3: Choose the coverage for yourself and eligible dependents

Persons to be enrolled ☐ Member ☐ Member and Spouse /Partner ☐ Member and Child ☐ Family

SECTION 4: Choose the coverage for yourself and eligible dependents

Please Note: If you or your dependents are Medicare-eligible, you must provide the SDCERA Health Plans Service Center with a copy of both sides of each of your signed Medicare cards showing Part A and B coverage. To enroll your eligible spouse or domestic partner, you must provide a copy of the marriage certificate or Certificate of Registration of Domestic Partnership from the California Secretary of State. To enroll eligible dependent children, you must provide a copy of the birth certificate or proof of adoption for each child. If you have additional enrollees, please list their information on a separate sheet and attach to your completed enrollment form.

Name	Relationship	Birth date	S.S.#	Medicare # (if applicable)

SECTION 5: Signature & Authorization

I elect the coverage as indicated above and certify that the information I have provided is true and accurate to the best of my knowledge. I also certify that I have read and understand the provisions of the medical plans, as detailed in the SDCERA *Health Insurance Plans* booklet and I agree to the terms and conditions stated therein. I agree to have my monthly retirement payment from SDCERA reduced by the required amount to pay my share (including covered dependent premiums) of the cost for the medical and/or dental plans(s) I have selected. I understand that I cannot change my coverage options until the next Open Enrollment period, but I can cancel my coverage at any time in writing or by calling the SDCERA Health Plans Service Center. Lastly, I also understand the SDCERA Board of Retirement reserves the right to modify or terminate the health insurance plans for my insurance coverage at any time.

SDCERA Health Plans Service Center
1.866.751.0256
PO Box 14464
Des Moines, IA 50306-3464
Fax: 515-365-1520

(Date) (Member Signature)

Health Net

Employer Group Enrollment Form

Main subscriber ID:

Effective date: M M D D Y Y Y Y

Please contact Health Net Seniority Plus (Employer HMO) if you need information in another language or format.

To enroll in Health Net, please provide the following information

Employer or union name:

Group #:

Last name:

First name:

Middle initial:

☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: M M D D Y Y Y Y

Sex: ☐ M ☐ F

Home phone number: – –

Alternate phone number: – –

Permanent residence street address:
(PO Box is not allowed)

City:

County:

State:

ZIP code:

Mailing address (only if different from your permanent residence address)
Street address:

City:

State:

ZIP code:

Please provide your Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

–OR–

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card)

Medicare number

Is entitled to: Effective date

HOSPITAL (Part A) M M D D Y Y Y Y

MEDICAL (Part B) M M D D Y Y Y Y

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

White – Health Net Yellow – Member

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

   If "Yes," retirement date: M M D D Y Y Y Y

   If "No," name of retiree:

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

   If "Yes," name of spouse:

   Name of dependents:

3. Do you or your spouse work? ☐ Yes ☐ No

4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis; otherwise, we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, workers' compensation, VA benefits, or State pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net?

   ☐ Yes ☐ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage:

   ID # for this coverage:

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

   If "Yes," please provide the following information:

   Name of institution:

   Phone number of institution: – –

   Address of institution (number and street):

7. Are you enrolled in your State Medicaid program? ☐ Yes ☐ No

   If "Yes," please provide your Medicaid number:

8. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as Original Medicare drug coverage since you became eligible to join a Medicare drug program?

   ☐ Yes ☐ No

Please choose a Primary Care Physician (PCP):

PCP access number: **Is this your current PCP?** ☐ Yes ☐ No

Please choose a Primary Care Physician Group (PPG):

Is this your current PPG? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese ☐ Large print ☐ Audio

Please contact Health Net at 1-800-275-4737 if you need information in an accessible format or language other than what is listed above. From October 1 through March 31, our office hours are 7 days a week from 8:00 a.m. to 8:00 p.m. From April 1 through September 30, our office hours are Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends and on federal holidays. TTY users should call 711.

Please read and sign below

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

Health Net 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.

Health Net serves a specific service area. If I move out of the area that Health Net serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Health Net 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 Health Net coverage begins, I must get all of my health care from Health Net, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net and other services contained in my Health Net *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET WILL PAY FOR THE SERVICES.**

Please read and sign below (cont.)

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

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 Health Net 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.

Signature:

Today's date:

M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone number: – –

Relationship to enrollee:

White – Health Net Yellow – Member

Please read and sign below

BINDING ARBITRATION: All benefits offered under this Medicare health plan, including optional supplemental benefits, if any, are subject to the Medicare appeals procedures and are not subject to arbitration. Conversely, all other claims including, but not limited to, the following claims, regardless of how they are characterized, are subject to arbitration: Determinations on items or services purchased by my employer, over and above the Medicare approved benefit package, such as payments of premiums or beneficiary cost-sharing provided by my employer, any disputes between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan that is not subject to the Medicare appeals process, including any claim for medical or hospital malpractice (a claim that medical services were unauthorized or were improperly, negligently or incompetently rendered), for premises liability, or relating to the delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under State law and not by lawsuit or resort to court process. By signing below, I agree to give up our right to a jury trial and accept the use of binding arbitration for claims that are not subject to the Medicare appeals procedures. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signature:

Today's date:

M M D D Y Y Y Y

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone number: – –

Relationship to enrollee:

OFFICE USE ONLY:

Name of staff member/agent/broker (if assisted in enrollment):

Rep ID #: Plan ID #:

Group #: Batch #:

Effective date of coverage:

M M D D Y Y Y Y

☐ ICEP/IEP ☐ AEP SEP (type): ☐ Not eligible

Health Net has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

White – Health Net Yellow – Member