SDCERA

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Health Insurance Plans Enrollment form

Please complete all sections of this form. You may submit your form online by selecting "Enrollment" on the Health page of www.sdcera.org or by mailing your form 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

(Date) (Member Signature)