SDCERA
San Diego County Employees Retirement Association

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 health.sdcera.org. You may also mail your forms to the SDCERA Health Plans Service Center, PO Box 14464, Des Moines, IA 50306-3464 or fax them to 515-365-1520.

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		☐ 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 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 published on the SDCERA website 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 the amount of my monthly pension benefit must exceed the full cost of the premium(s) being deducted. 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)