



## Medical Plan

### New Enrollment/Change/Cancellation Form

### Instructions

#### **Section I: Membership Information**

Fill in the personal information requested.

#### **Section II: Reason**

Check the box next to the reason you are completing this form (i.e., new enrollment, change medical plan, change of address, etc.).

#### **Section III: Family Information**

Fill in the information requested for yourself and any eligible dependents you want to cover.

*Print your name and Social Security number at the top of the second page.*

#### **Section IV: Medical Plan Information**

Check one plan for yourself and one plan for your eligible dependents. Provide additional information, if requested.

#### **Section V: Read and Understand/Authorization**

Carefully read each paragraph. Sign and date the form at the bottom on the lines provided.

*LACERA treats your and your family's personal health information as confidential. We follow the applicable sections of HIPAA related to privacy and security of your protected health information. If you have any questions about the steps taken to secure your protected health information, please refer to the HIPAA policy posted on the LACERA website, [www.lacera.com](http://www.lacera.com).*

**(FOR LACERA USE ONLY)** Deduction Code \_\_\_\_\_

Retirement Date \_\_\_\_\_ Effective Date \_\_\_\_\_ Years of Service \_\_\_\_\_ Current: Med: \_\_\_\_\_  
 New: Med: \_\_\_\_\_

SCD                       NSCD                      Input Date \_\_\_\_\_ Premium: Med: \$ \_\_\_\_\_

Please check one: Completed by      Retiree      Survivor      COBRA Participant

## SECTION I: Membership Information

Last Name (Print)		First Name (Print)		M.I.	Social Security Number
Street Address		Apt.	Date of Birth		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	ZIP Code	Home Phone Number ( )		Work Phone Number ( )
Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner: <input type="checkbox"/> Widowed:					
			Date of Marriage/Registration _____		Date of Death _____
<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership Terminated:					
Date of Divorce/Termination of Domestic Partnership _____					

**Current Medical Plan Coverage** is (write in the full name of plan): \_\_\_\_\_

**Other Medical Plan Coverage:** Please provide the name and policy number of any other medical plan that covers you or your dependents.  
 Name: \_\_\_\_\_ Policy No.: \_\_\_\_\_

## SECTION II: Reason

**New enrollment** (Go to Sections 3 and 4)

**Moving out of service area** of Kaiser, Kaiser Senior Advantage, PacifiCare, Secure Horizons, CIGNA, CIGNA HealthCare for Seniors, Blue Cross Prudent Buyer Plan or SCAN

**Name change:** Former Name \_\_\_\_\_ (write new name in Section I)

**Address change:** Former Address \_\_\_\_\_ (write new address in Section I)

**Re-enrollment for surviving spouse/domestic partner and/or dependent children:**  
 Name of Deceased Retiree \_\_\_\_\_ Social Security Number \_\_\_\_\_

**Other:** Explain \_\_\_\_\_

**Change medical plan** (Go to Sections 3 and 4)

**Cancel medical plan** (Go to Section 3)

**Add family member** (Go to Sections 3 and 4)

**Delete family member** (Go to Sections 3 and 4)

## SECTION III: Family Information

Relationship	Last Name	First Name	Middle Initial	Social Security Number	Birth Date	Sex (M/F)	Medical Coverage	Medicare Coverage
Retiree/ Survivor							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A&B <input type="checkbox"/> None Effective Date: _____
Spouse/ Domestic Partner*							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A&B <input type="checkbox"/> None Effective Date: _____
Dependent Child**							<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Child**							<input type="checkbox"/> Yes <input type="checkbox"/> No	

\* To cover your eligible spouse/dependent children/domestic partner, you must provide the original marriage certificate/birth certificate/Certificate of Registration of Domestic Partnership from the State of California. After verification, the original will be returned to you.

\*\* Please attach a copy of school certification for dependent children over age 19 or a copy of legal document for adopted children.



**SECTION IV: Medical Plan Information** Please check only one plan for yourself and your dependent(s):

HMO PLANS	MEDICARE PLANS	INDEMNITY PLANS
<input type="checkbox"/> <b>Kaiser Permanente</b> State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> <b>Kaiser Senior Advantage*</b> State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> <b>Blue Cross I</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> <b>CIGNA Network Model Plan</b> <input type="checkbox"/> Medical Group Healthplan <input type="checkbox"/> Private Practice Network <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) List medical group or physician name/number for yourself and each dependent: _____ _____	<input type="checkbox"/> <b>CIGNA HealthCare for Seniors*</b> <i>(available only in Phoenix, Arizona)</i> <input type="checkbox"/> Medical Group Healthplan <input type="checkbox"/> Private Practice Network <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) List medical group or physician name/number for yourself and each dependent: _____ _____	<input type="checkbox"/> <b>Blue Cross II</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> <b>PacifiCare</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a PacifiCare member, list your member number: _____ List name of medical group or IPA: _____ City: _____	<input type="checkbox"/> <b>PacifiCare Secure Horizons*</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a PacifiCare member, list your member number: _____ List name of medical group or IPA: _____ City: _____	<input type="checkbox"/> <b>Blue Cross Prudent Buyer Plan</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)  <i>Note: If you switch between any of the Blue Cross plans, the plan lifetime maximum will carry forward from one plan to another. For example, if you change from the Blue Cross Prudent Buyer Plan to Plan I or II, your accumulated expenses from the Prudent Buyer Plan will count toward your lifetime maximum for the new plan you've chosen.</i>
	<input type="checkbox"/> <b>SCAN*</b> <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)	
	<input type="checkbox"/> <b>Blue Cross III*</b> (Medicare supplement plan) <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)	

\*EACH ENROLLEE MUST ALSO COMPLETE A SEPARATE MA-PD FORM (EXCEPT ENROLLEES IN BLUE CROSS III). EACH PERSON (INCLUDING ENROLLEES IN BLUE CROSS III) MUST ATTACH A PHOTOCOPY OF HIS/HER MEDICARE CARD.

**SECTION V: Read and Understand/Authorization**

Please read the information on the back of this form then sign below to indicate your understanding and agreement.

Signed \_\_\_\_\_ Your Spouse's/Domestic Partner's Signature \_\_\_\_\_  
 Your signature or signature of guardian, conservator or power of attorney\*\* Your spouse's/domestic partner's signature or signature of guardian, conservator or power of attorney\*\*

Date \_\_\_\_\_ 20 \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

\*\*If this is submitted by a guardian or conservator, please attach the legal document establishing guardianship, conservatorship or the power of attorney to this form. Keep the last copy for your records. Return the top 2 copies along with any other appropriate forms to LACERA.

I understand that any dispute, including medical malpractice claims, between me (or someone with a relationship to me), Kaiser Foundation Health Plan, PacifiCare, CIGNA HealthCare, Blue Cross of California or SCAN, their contracting providers, or the physicians or employees of any of them, may be subject to binding arbitration (refer to the applicable Evidence of Coverage).

I understand that if I elect either CIGNA HealthCare for Seniors, Kaiser Senior Advantage, Secure Horizons or SCAN, this automatically disenrolls me from any other Medicare-contracting pre-paid health care plan in which I was enrolled. Additionally, I may voluntarily request disenrollment from any of the Medicare Advantage-Prescription Drug HMOs at any time. I may disenroll by submitting written notice directly to the Medicare Advantage-Prescription Drug HMO I am enrolled in, or through any Social Security Administration office.

I hereby enroll for the Group Health Coverage indicated above. I authorize the Los Angeles County Employees Retirement Association (LACERA) to make the necessary deductions from my retirement warrants for any contributions required of me and to send these contributions to the company chosen by me. I understand the LACERA Board of Retirement reserves the right to amend, revise, or discontinue these plans and programs at any time.

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO REPORT ANY CHANGE IN THE ELIGIBILITY OF MYSELF AND/OR MY DEPENDENTS TO LACERA IN WRITING WITHIN 30 DAYS OF THE CHANGE.**

I also understand that all of the benefits of these plans are coordinated with benefits provided by any other group, hospital or medical benefit or service plan, including Medicare.

I hereby authorize any physician, surgeon, practitioner or other person, any hospital including any medical service organization, insurance company, or any other institution to release to each other any medical or other information, including benefits paid or payable, on any sickness or illness that I now have or may sustain.