



Medical Plan

New Enrollment/Change/Cancellation

Please be sure to fill in ALL the required areas and provide ALL the required/necessary documents. Any missing information will cause a delay in processing this form.

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.

Please check one of the following boxes:

- New Enrollment** **Change** **Cancellation**

(FOR LACERA USE ONLY)	EFFECTIVE DATE _____	Deduction Code
Retirement Date _____	Years of Service _____	Current Med: _____
<input type="checkbox"/> SCD	Fax Date _____ Input Date _____	New Med: _____
<input type="checkbox"/> NSCD	Form # _____ Initials _____	Premium Med: \$ _____

Section I: LACERA Membership Information

Please check one: Completed by Retiree Survivor COBRA Participant

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	Contact Phone Number ()
			Alternate Phone Number ()
Email Address			
Marital Status (check one) <input type="checkbox"/> Single			
<input type="checkbox"/> Married, date of marriage _____			
<input type="checkbox"/> Divorced, date of divorce/legal separation _____			
<input type="checkbox"/> Widowed, date of death _____			
<input type="checkbox"/> Domestic Partner, date of registration _____			
<input type="checkbox"/> Domestic Partnership Terminated, date of termination _____			
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, UnitedHealthcare (formerly PacifiCare), SecureHorizons, CIGNA, CIGNA Medicare Select Plus Rx, Anthem Blue Cross Prudent Buyer Plan or SCAN

Name change: Former Name _____ (write new name in Section 1)

Address change: Former Address _____ (write new address in Section 1)

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 coverage (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	M.I.	SSN	Date of Birth	Sex (M/F)	Medicare Coverage
Retiree/ Survivor							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____
Spouse/ Domestic Partner*							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____

* 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.



Last Name (Print)

First Name (Print)

M.I. Social Security Number

SECTION IV: Medical Plan Information Please check only one plan which will cover you and your dependent(s):

HMO PLANS	MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS	INDEMNITY PLANS Benefits may differ by state
<input type="checkbox"/> Kaiser Permanente¹ State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR Benefits and premiums may differ by state <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"/> Kaiser Senior Advantage^{1,2} State of residence: <input type="checkbox"/> CA <input type="checkbox"/> CO <input type="checkbox"/> GA <input type="checkbox"/> HI <input type="checkbox"/> OR Benefits and premiums may differ by state <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"/> Anthem Blue Cross I <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <hr/> <input type="checkbox"/> Anthem Blue Cross II <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> CIGNA Network Model Plan¹ <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"/> CIGNA Medicare Select Plus Rx^{1,2} <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"/> Anthem Blue Cross Prudent Buyer Plan <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> UnitedHealthcare¹ (formerly PacifiCare) <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a UnitedHealthcare member, list your member number: _____ List name of medical group or Independent Practice Association (IPA): _____ City: _____	<input type="checkbox"/> SecureHorizons (by UnitedHealthcare)^{1,2} <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a SecureHorizons member, list your member number: _____ List name of medical group or Independent Practice Association (IPA): _____ City: _____ <hr/> <input type="checkbox"/> SCAN^{1,2} <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)	<i>Note: If you switch between any of the Anthem Blue Cross plans, the plan lifetime maximum will carry forward from one plan to another. For example, if you change from the Anthem 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>
	MEDICARE SUPPLEMENT PLAN <input type="checkbox"/> Anthem Blue Cross III² <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)	

¹ Subject to service area availability.

² Members enrolled in both Medicare Part A and Part B, who are enrolling in a Medicare Advantage Prescription Drug (MA-PD) plan (except those enrolling in Anthem Blue Cross III) must also complete an MA-PD Election form in order to assign their Medicare benefits. LACERA will provide the necessary MA-PD election form. Each individual enrolling in a MA-PD Plan and Anthem Blue Cross III must attach a photocopy of his/her Medicare card. Please do not send the original to LACERA.

SECTION V: Read and Understand/Authorization

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

Signed _____ Date _____ 20 _____

Your signature or signature of guardian, conservator or power of attorney*

Your Spouse's/Domestic Partner's Signature _____ Date _____ 20 _____

Your spouse's/domestic partner's signature or signature of guardian, conservator or power of attorney*

* 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 copy along with any other required/necessary documents to LACERA.

I understand that any dispute, including medical malpractice claims, between me (or someone with a relationship to me), Kaiser Foundation Health Plan, UnitedHealthcare, CIGNA HealthCare, Anthem 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 Medicare Select Plus Rx, Kaiser Senior Advantage, SecureHorizons 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.