



Medical Plan

New Enrollment/Change/Cancellation

To assist you in completing this form, a SAMPLE has been provided on www.lacera.com, under the Retiree Healthcare tab.

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

Section 1: Membership Information

Fill in the personal information requested.

Section 2: 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 3: 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 pages 2 – 6.

Section 4: Medical Plan Information

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

Section 5: Read, Understand, Sign and Date Health Plan Authorization

Section 6: Read, Understand, Sign and Date LACERA Authorization

Carefully read, sign and date the appropriate health plan arbitration language. Your completed form must be physically signed. No electronic signatures are accepted at this time.

To submit your form and documentation:

- Scan and upload your forms to My LACERA via lacera.com (recommended). This is the fastest method of submission, and you will receive a confirmation of receipt. OR
- Mail your forms to LACERA, P.O. Box 7060, Pasadena, CA 91109-7060. OR
- Fax your forms to 626-564-6155. OR
- Drop off your forms in the secure dropbox outside our Member Service Center at 300 N. Lake, Pasadena, CA 91101.

Remember to keep the bottom copy for your records.

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.

(FOR LACERA USE ONLY)

Retirement Date _____

Effective Date _____

Deduction Code

☐ SCD ☐ Tier 1

Years of Service _____

Current Med: _____ AME Entry Date: _____

☐ NSCD ☐ Tier 2 ☐ PPA Initials

Email/Fax Date _____

New Med: _____ Emp Site Entry Date: _____

Input Date _____ Initials _____

Premium Med: \$ _____

Section 1: LACERA MEMBERSHIP INFORMATION

Please check one:

Completed by ☐ Retiree ☐ Survivor ☐ COBRA Participant COBRA Period (months) ☐ 18 ☐ 29 ☐ 36

Last Name (Print)

First Name (Print)

M.I.

Social Security Number

Street Address

Apt.

Date of Birth

Sex: ☐ Male
☐ Female

City

State

ZIP Code

Email Address

Contact Phone Number
()

Alternate Phone Number
()

Marital Status (check one) ☐ Single

☐ Married, date of marriage _____ ☐ Divorced, date of divorce/legal separation _____

☐ Widowed, date of death _____ ☐ Domestic Partner, date of registration _____

☐ 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.: _____

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin

☐ Yes, Puerto Rican

☐ Yes, another Hispanic, Latino/a, or Spanish origin

☐ I choose not to answer

☐ Yes, Mexican, Mexican American, Chicano/a

☐ Yes, Cuban

What's your race? Select all that apply.

☐ American Indian or Alaska Native

☐ Chinese

☐ Japanese

☐ Other Asian

☐ Vietnamese

☐ I choose not to answer

☐ Asian Indian

☐ Filipino

☐ Korean

☐ Other Pacific Islander

☐ White

☐ Black or African American

☐ Guamanian or Chamorro

☐ Native Hawaiian

☐ Samoan



CONTINUE

Last Name (Print)

First Name (Print)

M.I.

Social Security Number

Section 2: REASON

- | | |
|---|---|
| <input type="checkbox"/> New enrollment (Go to Sections 3 and 4) | <input type="checkbox"/> Change medical plan (Go to Sections 3 and 4) |
| <input type="checkbox"/> Moving out of service area of Kaiser Permanente, Kaiser Permanente Senior Advantage, Kaiser Permanente CO, Kaiser Permanente HI, Kaiser Permanente GA, Kaiser Permanente OR, Kaiser Permanente WA, UnitedHealthcare, UnitedHealthcare Medicare Advantage, Cigna, Cigna with Preferred Rx, Anthem Blue Cross Prudent Buyer Plan, SCAN Health Plan, SCAN Desert Health Plan, and SCAN Health Plan Nevada. | <input type="checkbox"/> Cancel medical coverage (Go to Section 3) |
| <input type="checkbox"/> Name change: Former Name _____ (write new name in Section 1) | <input type="checkbox"/> Add family member (Go to Sections 3 and 4) |
| <input type="checkbox"/> Address change: Former Address _____ (write new address in Section 1) | <input type="checkbox"/> Delete family member (Go to Sections 3 and 4) |
| <input type="checkbox"/> Re-enrollment for surviving spouse/domestic partner and/or dependent children: | |
| Name of Deceased Retiree: _____ Social Security Number _____ | |
| <input type="checkbox"/> Other: Explain _____ | |

CONTINUE

SECTION 3: FAMILY INFORMATION

Relationship	Last Name	First Name	M.I.	SSN	Date of Birth	Sex (M/F)	Medicare Coverage	Medical Coverage
Retiree							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Survivor							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse*							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Partner*							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child**							<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Parts A & B <input type="checkbox"/> None Effec. date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

* To cover your eligible spouse/dependent children/domestic partner, provide a copy of your marriage certificate/birth certificate/Certificate of Registration of Domestic Partnership from the State of California, and a signed Attestation Form (contact LACERA for this form). If originals are submitted, they will be returned to you after verification. (NOTE: For enrollees in the Kaiser - Washington Out-of-State Plan, Washington State Registered Domestic Partners are treated the same as a spouse.)

** Please attach a copy of legal document for your adopted children. Eligible dependent children are eligible for coverage up to the age of 26 regardless of marital status, student status, or eligibility for coverage under another plan.

CONTINUE

SECTION 4: MEDICAL PLAN INFORMATION Please check only one plan which will cover you and your dependent(s):

HMO PLANS	MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS You must be enrolled in Medicare Parts A and B	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 <input type="checkbox"/> WA ³ Benefits and premiums may differ by state <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> Kaiser Permanente 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 <input type="checkbox"/> WA ³ Benefits and premiums may differ by state <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	<input type="checkbox"/> Anthem Blue Cross Plan I <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <hr/> <input type="checkbox"/> Anthem Blue Cross Plan II <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <hr/> <input type="checkbox"/> Anthem Blue Cross Prudent Buyer Plan <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 Preferred with Rx <i>(available in Maricopa County and Apache Junction, Pinal County, Arizona only)^{1,2}</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: _____	MEDICARE SUPPLEMENT PLAN You must be enrolled in Medicare Parts A and B <input type="checkbox"/> Anthem Blue Cross Plan III² <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s)
<input type="checkbox"/> UnitedHealthcare¹ <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a UnitedHealthcare member, list your member number: _____ List primary care physician's name, number, and medical group: _____ City: _____ Are you an existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> UnitedHealthcare Medicare Advantage^{1,2} <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) If you have been a UnitedHealthcare Medicare Advantage member, list your member number: _____ List name of medical group or Independent Practice Association (IPA): _____ City: _____ Are you an existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <input type="checkbox"/> SCAN Health Plan^{1,2} <input type="checkbox"/> Myself <input type="checkbox"/> Dependent(s) <input type="checkbox"/> AZ <input type="checkbox"/> CA <input type="checkbox"/> NV	<p><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></p>

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 (MAPD) plan (except those enrolling in Anthem Blue Cross III) must also complete an MAPD Election form in order to assign their Medicare benefits. LACERA will provide the necessary MAPD election form. Each individual enrolling in a MAPD Plan and Anthem Blue Cross III must attach a photocopy of his/her Medicare card. Please do not send the original to LACERA.

³ Kaiser Foundation Health Plan of Washington - 1300 SW 27th Street, Renton, WA 98057

CONTINUE AND SIGN

REMEMBER: SIGN IN TWO PLACES:

1. **You must provide your signature in Section 5: Binding Arbitration Agreement.**
 - If enrolling in a UnitedHealthcare, Cigna HealthCare, Anthem Blue Cross or SCAN Health Plan, **sign and date at the top of Page 5.**
 - If enrolling in a Kaiser Foundation Health Plan, **sign and date at the bottom of Page 5.**
2. **You must also provide your signature on Page 6** below the dotted lines.

IMPORTANT NOTE: If you submit this form without signing the appropriate arbitration language or affixing your signature on Page 6, this form will be considered incomplete and the start of your coverage may be delayed.

(CONTINUE NEXT PAGE)

SECTION 5: READ AND UNDERSTAND/AUTHORIZATION**Arbitration Agreement for UnitedHealthCare (UHC), Cigna HealthCare, Anthem Blue Cross of California and SCAN Health Plan:**

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute 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, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the health plan's coverage document, which is available for my review.

Signed _____ Date _____ 20 _____

Arbitration Agreement for Kaiser Foundation Health Plan - California

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signed _____ Date _____ 20 _____

Arbitration Agreement for Kaiser Foundation Health Plan - Hawaii

Except as provided in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement, any and all claims or disputes shall be resolved by binding arbitration. I acknowledge that I have read and understood the information in the Kaiser Foundation Health Plan Hawaii Arbitration Agreement (attached). I, on behalf of myself, all applicants, and all family members, hereby agree to binding arbitration and give up our constitutional rights to a jury or court trial.

Signed _____ Date _____ 20 _____

CONTINUE

IMPORTANT REMINDER:

Carefully read, sign and date the LACERA authorization on Page 6, below the dotted lines. Your completed form must be physically signed. No electronic signatures are accepted at this time.

If we receive the form with missing signatures, this form will be considered incomplete and the start of your coverage may be delayed.

(CONTINUE NEXT PAGE)

SECTION 6: READ AND UNDERSTAND/AUTHORIZATION (LACERA)

I understand that if I elect either Cigna Medicare Select Plus Rx (Phoenix, AZ only), Kaiser Permanente Senior Advantage, UnitedHealthcare Medicare Advantage or a SCAN Health Plan, 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 in Section 4 of this form. 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, or insurance company 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. This authorization will be valid for a period not to exceed 30 months past the date of my signature below.

Please carefully read the paragraphs above; 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**

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

* 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.

FOR LACERA USE ONLY

(FOR LACERA USE ONLY)

UHC/UHC MA		
Code Description	Group #	Group #
UHC MA		UHC
Check applicable box		
Member Only	<input type="checkbox"/> 004237	-
Mbr & Sp 1 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004238
Mbr & Sp 2 MDC	<input type="checkbox"/> 004237	-
Mbr/Sp/Ch 1 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004239
Mvr/Sp/Ch 2 MDC	<input type="checkbox"/> 004237	<input type="checkbox"/> 004240
Dep Child	-	<input type="checkbox"/> 147243
Commercial Mbr Only-Single	-	<input type="checkbox"/> 004241
Commercial Mbr + 1 Dep-Dual	-	<input type="checkbox"/> 004241
Commercial Mbr + Family-Family	-	<input type="checkbox"/> 004241

Kaiser Permanente (CA)		
Code Description	Group #	Group #
Check applicable box		
Kaiser Permanente	<input type="checkbox"/> 101002	
Kaiser Permanente Senior Advantage		<input type="checkbox"/> 101002
Kaiser Permanente Out-of-State		
Kaiser Permanente Colorado	<input type="checkbox"/> 11178-005	
Kaiser Permanente Hawaii	<input type="checkbox"/> 34628-001	
Kaiser Permanente Georgia	<input type="checkbox"/> 3221-100	
Kaiser Permanente Oregon	<input type="checkbox"/> 4310-001	
Kaiser Permanente Washington	<input type="checkbox"/> 2066600	