How to Complete Your Medical Plan ENROLLMENT Form – With SAMPLE

Follow the instructions below and refer to the attached sample to help you fill out and submit your medical plan enrollment form. Any missing information or documentation will cause a delay in processing your form. The sample provides detailed instructions for each of the different form sections.

How to Complete Your Form

Fill in **all** the required areas, referring to the sample form. All medical forms must be completed by the retiree, survivor, or guardian/conservator/attorney-in-fact.

You will need the following to fill out your form (as applicable):

- Social Security numbers for the enrollee and any dependents
- Medicare card or information
- Dates of birth, marriage, partnership, divorce/termination of partnership, or death for the enrollee and any dependents

If you are changing to a MAPD plan, you will also need to complete and submit an MAPD Election form. If enrolling a Medicare-eligible dependent, they will need to complete their own separate MAPD form.

If you have questions or need help with completing the form, call us at 800-786-6464.

How to Submit Your Form

Your completed form must be **physically signed** (even if you complete the fillable PDF form). **No electronic signatures are accepted at this time.**

You will need to submit **all five pages of the form** and **all the required documentation** in order for your plan enrollment to be processed.

You will need to provide the following documentation with your form, as applicable:

- **For spouses or partners:** photocopy of original marriage certificate or domestic partnership with the California Secretary of State
- **Photocopies of certificates must be accompanied by a signed attestation** certifying that the photocopy is a true and correct copy of the certificate and contains no alterations from the original.
- **For eligible dependent children:** photocopy of original certified birth certificate
- **For adopted children:** certified copy of the adoption order
- **For handicapped children:** current physical or mental handicap verification form, physician statement, proof of continuous coverage for handicapped child, and proof of financial support
- **For guardians, conservators, or attorneys-in-fact:** legal document establishing guardianship, conservatorship, or power of attorney

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 drop-box outside our Member Service Center at 300 N. Lake, Pasadena, CA 91101.

Remember to keep a 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.

LACERA

Los Angeles County Employees Retirement Association
PO Box 7060 • Pasadena, CA 91109-7060 • www.lacera.com

Please check one of the following boxes:

MEDICAL PLAN

☒ New Enrollment ☐ Change ☐ Cancellation

1

(FOR LACERA USE ONLY)	EFFECTIVE DATE	Deduction Code
Retirement Date_____	Years of Service _____	Current Med: _____ AME Entry Date: _____
☐ SCD ☐ Tier 1	Email/Fax Date _____	New Med: _____ Emp Site Entry Date: _____
☐ NSCD ☐ Tier 2 ☐ PPA Initials	Form # _____	Premium Med: $ _____
	Input Date _____ Initials ____	

1 Select the New Enrollment box.
Do not complete the gray section. (FOR LACERA USE ONLY)

Section 1

Section 1: LACERA MEMBERSHIP INFORMATION

2 Please check one:
Completed by ☐ Retiree ☐ Survivor ☐ COBRA Participant COBRA Period (months) ☐ 18 ☐ 29 ☐ 36

3

Last Name (Print)	First Name (Print)	M.I.	Social Security Number
DOE	JANE	A	XXX-XX-XXXX

Street Address	Apt.	Date of Birth	Sex: ☐ Male ☐ Female
ADDRESS		XX-XX-XXXX	

City	State	ZIP Code
ADDRESS	ADDRESS	ADDRESS

Email Address	Contact Phone Number	Alternate Phone Number
	(XXX)XXX-XXXX	(XXX) XXX-XXXX

4 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.: _____

2 Check the appropriate "completed by" box.
*COBRA participants: Check the COBRA participant box **and** the corresponding COBRA period.*

3 Fill in information where requested.

4 Check the appropriate marital status box and fill in dates where requested.

Section 2

Section 2: REASON

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

☐ **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.

☐ **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)

☐ **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 _____

5 Check the New enrollment box.

DOE	JANE	A	XXX-XX-XXXX
Last Name	First Name	M.I.	Social Security Number

6

6 On the top of page 2, fill out last name, first name, middle initial, and Social Security number in the space provided.

Section 3

SECTION 3: FAMILY INFORMATION

Relationship	Last Name	First Name	M.I.	SSN	Date of Birth	Sex (M/F)	Medicare Coverage
Retiree	DOE	JANE	A	xxx-xx-xxxx	01/01/9999	F	☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Survivor							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Spouse*							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Domestic Partner*							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____
Dependent Child**							☐ Part A ☐ Part B ☐ Parts A & B ☐ None Effec. date: _____

7 Provide the requested information for yourself and all covered dependents (last name, first name, middle initial, Social Security number, date of birth, and sex).

8 If signing up for a LACERA-administered Medicare plan, include your (and, if applicable, your dependent's) available Medicare coverage and effective date.

DOE	JANE	A	XXX-XX-XXXX
Last Name	First Name	M.I.	Social Security Number

9 On the top of page 3, fill out last name, first name, middle initial, and Social Security number in the space provided.

Section 4

11

SECTION 4: 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 You must be enrolled in Medicare Parts A and B	INDEMNITY PLANS Benefits may differ by state
10 ☐ **Kaiser Permanente**[1] State of residence: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA[3] Benefits and premiums may differ by state ☐ Myself ☐ Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	☐ **Kaiser Permanente Senior Advantage**[1, 2] State of residence: ☐ CA ☐ CO ☐ GA ☐ HI ☐ OR ☐ WA[3] Benefits and premiums may differ by state ☐ Myself ☐ Dependent(s) If previously a Kaiser Permanente member, provide last month and year of previous membership _____ Previous medical record number, if known _____	☐ **Anthem Blue Cross Plan I** ☐ Myself ☐ Dependent(s) ☐ **Anthem Blue Cross Plan II** ☐ Myself ☐ Dependent(s) ☐ **Anthem Blue Cross Prudent Buyer Plan** ☐ Myself ☐ Dependent(s)
☐ **Cigna Network Model Plan**[1] ☐ Medical Group Healthplan ☐ Private Practice Network ☐ Myself ☐ Dependent(s) List medical group or physician name/ number for yourself and each dependent: _____	☐ **Cigna Preferred with Rx** *(available in Maricopa County and Apache Junction, Pinal County, Arizona only)*[1, 2] ☐ Medical Group Healthplan ☐ Private Practice Network ☐ Myself ☐ 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 ☐ **Anthem Blue Cross Plan III**[2] ☐ Myself ☐ Dependent(s)
☐ **UnitedHealthcare**[1] ☐ Myself ☐ 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? ☐ Yes ☐ No	☐ **UnitedHealthcare Medicare Advantage**[1, 2] ☐ Myself ☐ 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? ☐ Yes ☐ No ☐ **SCAN Health Plans**[1, 2] ☐ Myself ☐ Dependent(s) ☐ AZ ☐ CA ☐ NV	*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.*

10 Select the healthcare plan for yourself and for any dependents. If appropriate, select the state you reside in.

11 If you and/or your eligible dependent is enrolling in an MAPD plan, you will also need to complete and submit a separate MAPD enrollment form and a copy of your and/or your eligible dependent's Medicare Part A and B card.

DOE	JANE	A	XXX-XX-XXXX
Last Name	First Name	M.I.	Social Security Number

12

12 On the top of page 4, fill out last name, first name, middle initial, and Social Security number in the space provided.

Section 5

SECTION 5: READ AND UNDERSTAND/AUTHORIZATION

13

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_____

13 Carefully read, sign and date the LACERA authorization. Your completed form must be physically signed. No electronic signatures are accepted at this time.

DOE	JANE	A	XXX-XX-XXXX
14 Last Name	First Name	M.I.	Social Security Number

14 On the top of page 5, fill out last name, first name, middle initial, and Social Security number in the space provided.

SECTION 5: READ AND UNDERSTAND/AUTHORIZATION

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.

15 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.

15 Carefully read, sign and date the LACERA authorization. Your completed form must be physically signed. No electronic signatures are accepted at this time.