SFHSS LIVE OR WORK ENROLLMENT APPLICATION: CITY & COUNTY OF SAN FRANCISCO EMPLOYEE FOR JANUARY–DECEMBER 2019 PLAN YEAR

To enroll in an HMO plan on the basis of a qualifying work location, please complete this Application and return with eligibility documentation, including a Live or Work Rule Member Certification Form, to San Francisco Health Service System (SFHSS) by the required deadlines. Contact SFHSS at (415) 554-1750.

1 APPLICATION TYPE

☐ New Hire ☐ Rehire/Reinstatement

Status Change: ☐ Birth/Adoption ☐ Marriage/Partnership ☐ Separation/Dissolution/Divorce ☐ Ineligible ☐ Other Coverage ☐ Other _____

2 YOUR PERSONAL INFORMATION

Last Name	First Name	Initial	DSW

Social Security Number	Birth Date MM/DD/YYYY	Gender M/F	Home/Cell Telephone Number

Email Address	Work Telephone Number

3 WORK ADDRESS

Department Name	Street Address	City	State	Zip Code

4 HOME ADDRESS

Department Name	Street Address	City	State	Zip Code

5 CHOOSE YOUR MEDICAL PLAN (includes Basic VSP)[2]

☐ Blue Shield Trio HMO[1] ☐ Blue Shield Access+ HMO[1]
☐ City Plan PPO ☐ Kaiser HMO[1] ☐ No Medical Coverage

6 CHOOSE YOUR DENTAL PLAN

☐ Delta Dental PPO ☐ UnitedHealthcare Dental DHMO[1]
☐ Deltacare USA DHMO[1] ☐ No Dental Coverage

7 UPGRADE YOUR VISION PLAN[2]

☐ VSP Premier Plan[3]

[1] To enroll in an HMO/DHMO Plan, you must live in an area serviced by the HMO/DHMO. [2] Enrollment in any medical plan automatically includes enrollment in the VSP Basic Vision Plan.
[3] VSP Premier Plan is an additional cost. To enroll in the Plan, you and your dependents must be enrolled in a medical plan and all dependents must also enroll in the VSP Premier Plan.

8 TO ADD OR DROP DEPENDENTS FROM YOUR MEDICAL AND/OR DENTAL COVERAGE, PLEASE LIST BELOW.

You must submit required eligibility documentation for the initial enrollment of any dependents. See the reverse side of this Form for more information.

Medical	Dental	Last Name	First Name	Birth Date	M/F	Social Security Number	Relationship
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						

9 You must enroll every year you want to elect a Flexible Spending Account. FSA Administrator: P&A Group

☐ Yes, I want a Healthcare Flexible Spending Account. I want to contribute a total annual amount of $ _____ January–December 2019.
(Annual amount will be divided equally by the remaining eligible pay periods in the calendar year). (Min $250 - Max $2,650)

☐ Yes, I want a Dependent Care Flexible Spending Account. I want to contribute a total annual amount of $ _____ January–December 2019.
(Annual amount will be divided equally by the remaining eligible pay periods in the calendar year). (Min $250 - Max $5,000)

City & County of San Francisco employees are eligible for Voluntary Benefits. Voluntary Benefits are administered by WORKTERRA (EBS). To enroll in Voluntary Benefits, please visit workterra.com or call WORKTERRA (EBS) at (888) 392-7597.

10 SIGNATURE & CERTIFICATION

Under penalty of perjury I certify that the information entered on this document is true and correct. I give the persons administering the plans in which I enroll and/or their agents permission to verify all information. It is my responsibility to notify the San Francisco Health Service System (SFHSS) when a dependent becomes ineligible. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify plans and SFHSS for any benefits paid if I or my dependents prove to be ineligible. I understand falsification of information may violate applicable laws, rules and regulations, leading to dismissal and/or legal action. **I have read and accept the terms and conditions on this side and the reverse side of this form**. A copy of this form is as valid as the original.

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT:

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.

Signature: Date Signed:

Mail or drop off this form in person to: SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103 • SFHSS Member Services Phone: (415) 554-1750
Fax forms to: (415) 554-1721 • *Please do not fax the same application multiple times.* • **Keep a copy of this form for your records.**

SFHSS USE ONLY *Enrolled by:*_____ *Date:* _____ *Processed by:* _____ *Date:* _____

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:

- The San Francisco Health Service System (SFHSS) will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- You agree to complete and submit to the plan provider any necessary forms, consents, releases, assignments, applications, questionnaires and other documents that the plan or SFHSS may reasonably request.
- **You agree to submit any contribution required on your part and authorize SFHSS to deduct from your wages any contributions required on your part to provide healthcare coverage for yourself and any enrolled dependents. These amounts will be paid to the benefit plans you have selected. The deductions will occur during each coverage period, typically each pay period. This deduction may also include past due amounts.**
- You agree to submit any contribution required on your part directly to SFHSS during any unpaid leave of absence.
- Your participation in the SFHSS is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of SFHSS as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during January–December 2019 unless you have a qualifying family status change. Refer to your Benefits Guide for complete details.
- Any misrepresentation of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to reimbursement of premium and claims costs on a retroactive basis, disciplinary action, dismissal and/or legal action.
- The terms and conditions of each medical/dental plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by SFHSS, the terms and conditions of the plan documents will govern.
- You understand that **some of the health plans offered by SFHSS contain a clause requiring resolution of medical malpractice and other disputes through binding arbitration**. This clause expressly provides that when you select the applicable plan, you give up the right to a jury or court trial for resolution of these disputes. To determine whether the plan you have selected contains such a clause and, if so, what the exact terms and conditions of such clause are, consult the individual plan document available through applicable plan provider.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through SFHSS, you will promptly notify SFHSS and submit all requested documentation. Dependent eligibility may be audited by SFHSS and proof of dependent eligibility may be required at any time.
- You understand that you or any dependent listed on this form who has End Stage Renal Disease may be prohibited by law from changing health plan enrollment.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by SFHSS.
- Any of the health plans offered by SFHSS may require documented verification of any Disabled Adult Child Dependent.
- The following documentation is required, in addition to a completed SFHSS Health Benefits Enrollment Application, for any eligible individual's enrollment. SFHSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTATION

In addition to social security numbers for each eligible plan participant, you must also supply the following documentation listed below.

	CERTIFIED MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	SOCIAL SECURITY #
Employee: Permanent/Provisional							■
Employee: Temporary/Exempt							■
Spouse	■						■
Domestic Partner		■					■
Child: Natural			■				■
Step Child: Spouse	■		■				■
Step Child: Domestic Partner		■	■				■
Child: Adopted				■			■
Child: Placed for Adoption					■		■
Child: Legal Guardianship (Up to Age 19)						■	■
Child: Court Ordered (Up to Age 19)						■	■
Adult Child: Disabled			■				■

Proof of Medicare enrollment is also required for a legal domestic partner who is Medicare eligible due to age or disability.
If you have questions about eligibility or required documentation contact SFHSS Member Services at (415) 554-1750.