HEALTH BENEFITS ENROLLMENT APPLICATION: COMMISSIONERS FOR JANUARY–DECEMBER 2026 PLAN YEAR

You must submit a completed enrollment application and required eligibility documents to the San Francisco Health Service System (SFHSS) **within 30 days** of your initial benefits eligibility date, qualifying life event (QLE), or within the Open Enrollment (OE) period. Refer to your Benefits Guide or visit **sfhss.org** for more details.

1 APPLICATION TYPE

☐ New Hire ☐ Open Enrollment

QUALFYING LIFE EVENTS (Select One) ☐ Birth/Adoption ☐ Marriage/Partnership ☐ Separation/Dissolution/Divorce ☐ Ineligible ☐ Other Coverage ☐ Other _____

2 YOUR PERSONAL INFORMATION

Full Name (First, Middle, Last)			DSW
Street Address (no P.O. Boxes)	City	State	Zip Code
Social Security Number (SSN)	Birth Date MM/DD/YY	Gender	Home/Cell Telephone Number
Email Address			Work Telephone Number

3 YOUR MEDICAL PLAN (includes Basic VSP)[2]

☐ Trio HMO[1] (Blue Shield) ☐ Access+ HMO[1] (Blue Shield)
☐ Kaiser Permanente HMO[1] ☐ Blue Shield of CA PPO
☐ Health Net CanopyCare HMO[1] ☐ Waive Medical Coverage

4 YOUR DENTAL PLAN

☐ Delta Dental PPO ☐ Deltacare USA DHMO[1]
☐ UnitedHealthcare Dental DHMO[1]
☐ Waive Dental Coverage

5 VISION PLANS

☐ VSP Basic Plan[2] ☐ VSP Premier Plan[3]

If you are currently enrolled in the VSP Premier Plan, you and your dependents will automatically be re-enrolled in the VSP Premier Plan next year. If you do not wish to re-enroll in VSP Premier, check the VSP Basic Plan box.

[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 this plan, you and your dependents must enroll in medical coverage. By selecting the VSP Premier Plan all dependents will be enrolled in the plan.

6 TO ADD OR DROP SELF AND/OR DEPENDENTS FROM MEDICAL AND/OR DENTAL COVERAGE

You must submit required eligibility documents for the initial enrollment of any dependents and at anytime when audited by SFHSS. Attach additional sheet if necessary.

Full Name (First, Middle, Last)	Birth Date MM/DD/YYYY	SSN	Gender	Relationship	Medical	Dental	PCP ID*
				SELF	Add ☐ Drop ☐	Add ☐ Drop ☐	
					Add ☐ Drop ☐	Add ☐ Drop ☐	
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*When enrolling in a Blue Shield HMO Plan ONLY, you can select a Primary Care Physician (PCP) for yourself and your dependents. PCP enrollment is not guaranteed and is subject plan confirmation.

7 SALARY REDUCTION AGREEMENT & SIGNATURE

Under penalty of perjury I certify that the information entered on this document is true and correct. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for any allowed pre-tax coverage. Such reductions, considered as elective contributions under the plan shall commence on the first payroll cycle that my coverages go into effect. I understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of Section 125 of the Internal Revenue Code. Coverages allowed by this code include medical, dental, and vision. **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

If you have selected the Kaiser Plan, by submitting your enrollment application, you are agreeing to Kaiser 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:

Mail or drop off this form in person to: SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103. • Fax forms to: (628) 652-4701

SFHSS Member Services Phone: (628) 652-4700. • **Please do not fax the same application multiple times. • Keep a copy of this form for your records.**

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

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

ELIGIBILITY & ENROLLMENT

- SFHSS will enroll you and your eligible dependents only in the benefits selected on this form and for which you qualify.
- You are responsible for submitting any forms, consents, or documents reasonably requested by SFHSS or your plan provider to complete enrollment or verify eligibility.
- If you or any dependent becomes ineligible for SFHSS coverage, you must promptly notify SFHSS and provide requested documentation. Eligibility may be audited at any time.

PLAN PARTICIPATION & CHANGES

- Your benefit elections remain in effect for the plan year and may only be changed during Open Enrollment or following a qualifying life event (e.g., marriage, divorce, birth, adoption, loss of other coverage), consistent with SFHSS Rules.
- If you take an unpaid leave, you are responsible for submitting any required premium contributions directly to SFHSS.

COMPLIANCE & MISREPRESENTATION

- Your participation is subject to all applicable laws, and SFHSS rules and regulations, which may change over time.
- Any misrepresentation of eligibility or other information on this form may result in retroactive repayment of premiums or claims, disciplinary action (including dismissal), or legal consequences.
- Benefits paid on behalf of ineligible individuals are subject to recovery by SFHSS or the health plan.

PLAN TERMS & ARBITRATION

- The terms and conditions of your coverage are governed by the plan documents provided by each plan provider. If there is a discrepancy between SFHSS materials and the plan documents, the plan documents take precedence.
- Some health plans require resolution of disputes—including medical malpractice claims—through binding arbitration. By enrolling in such a plan, you waive your right to a jury or court trial. Refer to the specific plan document for full arbitration details.

AUTHORIZATION TO RELEASE INFORMATION

- You authorize medical or dental providers to release service-related information, records, or images to the health plan and its agents, as permitted by law, for purposes such as cost review, quality assessment, and utilization analysis.

DISCLAIMER

The content on this page has been edited and organized using Generative AI for clarity and readability. It is provided for informational purposes only and does not replace or override the official plan documents or SFHSS rules; in the event of any conflict, the official documents will govern.

REQUIRED ELIGIBILITY DOCUMENTS

	CERTIFIED MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	SOCIAL SECURITY CARD
Spouse	■						■
Domestic Partner		■					■
Child: Natural			■				■
Step Child: Spouse	■		■				■
Step Child: Domestic Partner		■	■				■
Child: Adopted				■			■
Child: Placed for Adoption					■		■
Child: Legal Guardianship/Court Order (Up to Age 19)						■	■

Proof of Medicare enrollment is also required for a registered domestic partner who is Medicare eligible due to age or disability.
Please visit sfhss.org for full eligibility requirements.