HEALTH BENEFITS ENROLLMENT APPLICATION: RETIREE OR DEPENDENT(S) WITH MEDICARE FOR JANUARY–DECEMBER 2026 YEAR PLAN

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.

❶ APPLICATION TYPE (Select one)

☐ Retirement ☐ Open Enrollment

QUALIFYING LIFE EVENT

☐ Birth/Adoption ☐ Marriage/Partnership ☐ Separation/Dissolution/Divorce

☐ Ineligible ☐ Other Coverage ☐ Other _____

❷ YOUR PERSONAL INFORMATION

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

❸ YOUR MEDICARE INFORMATION

Complete this section if you are eligible for Medicare. If you are not yet eligible for Medicare, leave this section blank.

Medicare Claim Number (On Medicare card)	Medicare Part A Effective Date (MM/DD/YYYY)	Medicare Part B Effective Date (MM/DD/YYYY)

❹ MEDICAL PLAN (includes Basic VSP)[2,5]

☐ Blue Shield of California Medicare Advantage PPO

Coverage for Individual Not Eligible for Medicare[1,4]:

☐ Trio HMO (Blue Shield) ☐ Access+ HMO (Blue Shield) ☐ Blue Shield of California Non-Medicare PPO

☐ Kaiser Permanente Senior Advantage HMO[1] ☐ Waived Medical Coverage

❺ DENTAL PLAN[5]

☐ Delta Dental PPO ☐ UHC Dental DHMO[1] ☐ Deltacare USA DHMO[1] ☐ Waived Dental Coverage

❻ VISION PLANS

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.

☐ Vision Basic Plan[2] ☐ Vision 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 this plan, you and your dependents must be enrolled in a medical plan and all dependents must also enroll in the VSP Premier Plan. [4]Applicable only if Blue Shield of California Medicare Advantage PPO has been selected for the Medicare eligible individual. [5]For new Retirees who wish to enroll in COBRA, follow the instructions on the COBRA application that you receive from P&A Group. **SFHSS does not process COBRA enrollment.**

❼ TO ADD OR DROP SELF AND/OR DEPENDENT(S) 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 an additional sheet if necessary.

Full Name (First, Middle, Last)	SSN	Gender	Relationship	Medical		Dental		PCP ID*
				Add ☐	Drop ☐	Add ☐	Drop ☐	
				Add ☐	Drop ☐	Add ☐	Drop ☐	
				Add ☐	Drop ☐	Add ☐	Drop ☐	

**When enrolling in a Blue Shield HMO Plan ONLY, you can select a Primary Care Physician (PCP) for your self and your dependents. PCP enrollment is not guaranteed and is subject plan confirmation.*

❽ DEPENDENT(S) MEDICARE INFORMATION

List all Medicare-eligible dependents, attach additional sheet if necessary. If dependents are not Medicare-eligible, leave blank.

Full Name (First, Middle, Last)	Medicare Claim Number (On Medicare card)	Medicare Part A (Effective Date MM/DD/YYYY)	Medicare Part B (Effective Date MM/DD/YYYY)
Full Name (First, Middle, Last)	Medicare Claim Number (On Medicare card)	Medicare Part A (Effective Date MM/DD/YYYY)	Medicare Part B (Effective Date MM/DD/YYYY)
Full Name (First, Middle, Last)	Medicare Claim Number (On Medicare card)	Medicare Part A (Effective Date MM/DD/YYYY)	Medicare Part B (Effective Date MM/DD/YYYY)

❾ 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 the San Francisco Health Service System (SFHSS) to reduce my pension in the amount necessary to pay for coverage elected in this document for which I am eligible for. I further understand that should my pension not be enough to pay for my elected coverage, I will pay the SFHSS directly to retain such coverage. **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. *Please do not fax the same application multiple times.* SFHSS Member Services: (628) 652-4700. *Keep 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

- San Francisco Health Service System (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.

WASHINGTON

- Washington OIC Custom Enrollment Requirements for Washington enrollees are included into this Application by reference.

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.

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Custom Enrollment Requirements for Washington State

1. **Dependent Eligibility**
    a. Dependents are not required to reside with the subscriber.
    b. Dependents are not required to be dependent upon the subscriber for support.
    c. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments.
    d. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan.

2. **Domestic Partners**
    a. Washington State Registered Domestic Partners are treated the same as a spouse.
    b. If children of the primary insured are covered, children of Domestic Partners are eligible for coverage on the same basis.

3. **Fraud Statement** - 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.

4. **Producers** - Washington regulators recognize the term Producer rather than Agent or Broker.

5. **Plans issued by** - Kaiser Foundation Health Plan of Washington
    2715 Naches Ave. SW
    Renton, WA 98057

    Kaiser Foundation Health Plan of Washington Options, Inc.
    2715 Naches Ave. SW
    Renton, WA 98057

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VOLUNTARY IDENTIFICATION OF RACE AND ETHNIC ORIGIN FOR APPLICANT WITH OR WITHOUT DEPENDENT(S)

SFHSS is aligning with leading health authorities to ensure that equity is engrained within the fabric of our mission, vision, values, and strategic goals. To reduce disparities, we must begin with accurate data collection. We believe the collection of this optional data will meaningfully advance equity mandates. Plan enrollment will not be affected if you choose not to provide this information.

APPLICANT

Last Name	First	Middle	DSW

What is your race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islande
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are you of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

DEPENDENT #1

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islande
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

DEPENDENT #2

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islande
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

VOLUNTARY IDENTIFICATION OF RACE AND ETHNIC ORIGIN FOR APPLICANT WITH OR WITHOUT DEPENDENT(S)

DEPENDENT #3

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islande
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

DEPENDENT #4

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islande
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

PRIVACY NOTICE ON VOLUNTARY INFORMATION COLLECTION

I, hereby, understand that completion of this form is not required and is therefore completely voluntary. The San Francisco Health Service System (SFHSS) is committed to diversity, equity, and inclusion and uses provided demographic information to help ensure equity and reduce disparities in healthcare and health outcomes.

SFHSS is committed to maintaining the privacy of your personal information. You have a right to review, change, or correct any demographic information that you gave to SFHSS. Please contact Member Services to review, change or correct any personal information that you have provided SFHSS, please visit https://sfhss.org/contact-us.

For more information on the Citywide Race/Ethnicity Data Standard, please visit the Office of Racial Equity (ORE) webpage at https://www.racialequitysf.org/race-ethnicity-data-standard, and for more information on the SFHSS Strategic Plan, please visit https://sfhss.org/sfhss-strategic-plan-2023-2025.

Signed:_____ Date: _____

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