COBRA ENROLLMENT/CHANGE FORM

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

COVERAGE
- ☐ HEALTH
- ☐ DENTAL
- ☐ VISION
- ☐ EAP
- ☐ MRA

COVERAGE LEVEL

☐ SINGLE	☐ FAMILY
☐ SINGLE	☐ FAMILY
☐ SINGLE	☐ FAMILY
☐ SINGLE	☐ FAMILY

☐ **NEW ENROLLMENT**
☐ **CHANGE ENROLLMENT**

COVERAGE EFFECTIVE DATE _____

☐ **KAISER PERMANENTE $25 Copay HMO –** Group #887
☐ **KAISER PERMANENTE $1500 Deductible HMO–** Group #887
☐ **KAISER PERMANENTE $3000 Deductible HMO—**Group #887
☐ **SUTTER HEALTH PLUS $20 Copay HMO –** Group #777000
☐ **SUTTER HEALTH PLUS $1500 Deductible HMO –** Group #777000
☐ **SUTTER HEALTH PLUS $2500 Deductible HMO—**Group 777000
☐ **BLUE SHIELD $100 Deductible PPO –** Group #W0051445

☐ **DELTA DENTAL PPO – Group #2584**
☐ **DELTACARE HMO – Group #5643**

☐ **VSP VISION – Group # 12112926 - SIGNATURE**
☐ **VSP VISION – Group # 12112926 - CHOICE**

☐ **EAP (Sworn/MEF Dispatchers)** ☐ **EAP (Non-Sworn)**

☐ **MRA (Medical Reimbursement Account)**

COBRA Primary Participant Information:

Social Security Number	Last Name	First Name	M.I.	Date of Birth

Address	City	State	Zip	
				☐ Male ☐ Female

Telephone Number	Employee ID of covered employee	
Home ( ) Work ( ) Other ( )		☐ Single ☐ Married

REQUEST TO COVER DEPENDENTS

	Last Name	First Name	Date of Birth	Social Security Number	Male or Female	Age 19 - 23 FT Student Status?		Please circle the benefit plan type(s) you would like to enroll each dependent.
Spouse/ Dom. Partner						N/A	N/A	Health Dental Vision EAP
Child						Yes	No	Health Dental Vision EAP
Child						Yes	No	Health Dental Vision EAP
Child						Yes	No	Health Dental Vision EAP
Child						Yes	No	Health Dental Vision EAP
Child						Yes	No	Health Dental Vision EAP

Are you or your dependent(s) covered under another: **Health plan**: Yes No **Dental Plan**: Yes No **Vision Plan**: Yes No

FORM CONTINUED ON REVERSE ⇨

SIGNATURE(S) REQUIRED

Enrollees in Kaiser must sign the top signature line and bottom signature line.
Enrollees in Sutter Health Plus must sign the middle signature line and bottom signature line.
Enrollees in all other plans must sign only the bottom signature line.

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 Required for Kaiser Permanente Plan **Date**

Sutter Health Plus Plan Arbitration Agreement

Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Evidence of Coverage and Disclosure Form.

_____ _____

Signature Required for Sutter Health Plus Plan **Date**

I authorize my health plan carrier to release or obtain medical information on myself and covered dependents to or from health care providers/ agencies for the purpose of providing necessary health care services, utilization review, quality assurance, surveys, processing of claims, financial audit or purposes reasonably related to the performance of the agreement or policy. I also agree to be bound by the benefits, limitations, exclusions and other terms of the Group Agreement and any amendments to the Group Agreements. I understand that only my legal dependents, as defined by the City of San José, may be enrolled in my health, dental, vision, and EAP plans. *I declare that all the information provided herein is true and correct.*

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Signature Required for COBRA Primary Participant **Date**