CITY OF CHICO

HEALTH INSURANCE ELECTION FORM

❑ New Enrollment
❑ Qualifying Event
Event Type: ____________________
Event Date: ____________________

Insurance Effective Date: ______________________

EMPLOYEE INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:
Sex: ❑ Male ❑ Female	Social Security Number:	Primary Phone:	Secondary Phone:
Mailing Address:	City:	State:	Zip:
Medicare: ❑ None ❑ Part A ❑ Part B	Medicare Claim/HICN #:	Email Address:	

Marital Status: ❑ Single ❑ Married ❑ Registered Domestic Partner ❑ Legally Separated ❑ Divorced

ENROLLMENT

SELF

Coverage: **Medical -** ❑ PPO 90/10 ❑ PPO 80/20 ❑ EPO ❑ HDHP ❑ Decline Medical Coverage
Dental & Vision - ■ Elected (Non-Voluntary)

SPOUSE / REGISTERED DOMESTIC PARTNER

Last Name:	First Name:	Date of Birth:
Sex: ❑ Male ❑ Female	Social Security Number:	Marriage Date:
Medicare: ❑ None ❑ Part A ❑ Part B	Medicare Claim/HICN #:	Spouse Phone:

Coverage Elected: ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

CHILD(REN)

Last Name:	First Name:	Date of Birth:
Sex: ❑ Male ❑ Female	Social Security Number:	Coverage Type: ❑ Under Age 26 ❑ Disabled
Medicare: ❑ None ❑ Part A ❑ Part B	Medicare Claim/HICN #:	Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child

Coverage Elected: ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

Last Name:	First Name:	Date of Birth:
Sex: ❑ Male ❑ Female	Social Security Number:	Coverage Type: ❑ Under Age 26 ❑ Disabled
Medicare: ❑ None ❑ Part A ❑ Part B	Medicare Claim/HICN #:	Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child

Coverage Elected: ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

Last Name:	First Name:	Date of Birth:
Sex: ❑ Male ❑ Female	Social Security Number:	Coverage Type: ❑ Under Age 26 ❑ Disabled
Medicare: ❑ None ❑ Part A ❑ Part B	Medicare Claim/HICN #:	Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child

Coverage Elected: ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

ACKNOWLEDGEMENT: I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements. I also attest that by signing below that I agree to the legal disclaimers on Page 2 of this application.

Signature: ____ **Date:** ______________________

HUMAN RESOURCES USE ONLY			
Plan Elections:	**Medical**	❑ Single ❑ Double ❑ Family ❑ None Plan: ____________	❑ **Entered into Payroll**
	Dental	❑ Single ❑ Double ❑ Family ❑ None	❑ **Workterra Updated**
	Vision	❑ Single ❑ Double ❑ Family ❑ None	**Date/Initials:** __________

LEGAL DISCLAIMERS

Deduction authorization: If applicable, I authorize my employer to deduct from my wages the required premiums. I acknowledge that my premium deductions shall be taken as a pre-tax deduction in accordance with the City of Chico's Section 125 plan and IRS regulations.

Non-participating provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV testing prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Effective date: The effective date of coverage is subject to Anthem approval. Typically, the effective date is the first of the month following the qualifying event.

Declination of Coverage: The available coverages have been explained to me by my employer. By signing below, I certify that I am electing and declining the coverage offered to me and my dependents by the City, as listed above. If I am declining coverage, I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. I also, acknowledge that my dependents and I have to wait until Open Enrollment or a qualifying event to enroll in declined coverage(s).

CSAC-EIA Health Insurance: Authorization to obtain or release medical information explanation: The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. Seq. of the California Civil Code. Your cooperation is being requested. Authorization to obtain or release medical information: I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self-insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim. Arbitration Agreement: ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, 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 arbitration.* YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten" signature, you acknowledge that such signature is valid and binding.

Delta Dental: Active Employees: I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Registered Domestic Partner: To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Social Security Numbers: Anthem is required by the Internal Revenue Service to collect this information for all participants over the age of 6 months. I certify each Social Security number listed on this application is correct.