County of Sacramento, Employee Benefits Office
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WEB: http://www.personnel.saccounty.net/Benefits/Pages/default.aspx

EMPLOYEE LIFE EVENT FORM

DATE STAMP AREA

REASON FOR CHANGE: ____________________ **DATE OF EVENT:** ____________

1 EMPLOYEE INFORMATION

Last Name | First Name | M.I

Personnel ID # | Phone | Email

2 MEDICAL COVERAGE

☐ NO CHANGE ☐ Tier A
☐ ENROLL ☐ Tier B*
☐ WAIVE**

☐ **KAISER PERMANENTE**
☐ **SUTTER HEALTH PLUS**
☐ **WESTERN HEALTH ADVANTAGE**

☐ HMO
☐ HIGH DEDUCTIBLE

☐ SINGLE COVERAGE
☐ FAMILY COVERAGE

***See "*TIER B" or "WAIVER OF COVERAGE" section on back of form**

3 OPTIONAL VISION

☐ NO CHANGE
☐ ENROLL
☐ WAIVE**
☐ SINGLE COVERAGE
☐ FAMILY COVERAGE

***See "WAIVER" OF COVERAGE" section on back of form**

5 DENTAL COVERAGE

☐ NO CHANGE
☐ SINGLE COVERAGE
☐ FAMILY COVERAGE

4 HEALTH SAVINGS ACCOUNT

$____________ ☐ ENROLL ☐ CHANGE

Under age 55 max	Single-$3,500	Family-$7,000
Over age 55 max	Single-$4,500	Family-$8,000

6 FLEXIBLE SPENDING ACCOUNTS

☐ **General MRA** $2,500 max $____________

☐ **DCRA** $5,000 max $____________

☐ **Limited MRA** $2,500 max $____________

7 SELF/DEPENDENT COVERAGE ELECTIONS

							Cover	Drop
You	SSN	Birthdate		Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐
Spouse/ Domestic Partner	Last Name SSN	First Name Birthdate	☐M ☐F	Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐
Child ☐M ☐F	Last Name SSN	First Name Birthdate	Disabled ☐	Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐
Child ☐M ☐F	Last Name SSN	First Name Birthdate	Disabled ☐	Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐
Child ☐M ☐F	Last Name SSN	First Name Birthdate	Disabled ☐	Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐
Child ☐M ☐F	Last Name SSN	First Name Birthdate	Disabled ☐	Dr Name Dr ID Number	Existing Patient? ☐Y ☐N	Med Dental Vision	☐ ☐ ☐	☐ ☐ ☐

TURN OVER FOR SIGNATURE, FORM NOT VALID UNLESS SIGNED BY EMPLOYEE

INSTRUCTIONS: If you are waiving coverage, read and initial the Waiver of Coverage section, then read and sign and date at the bottom. For all other changes, read and initial the arbitration agreement next to your selected plan, then read and sign and date at the bottom "X".

***TIER B: I understand this election is irrevocable and forfeits all entitlements to cashback/PSI. Initials: _____ (also sign at "X" below)**

****WAIVER OF COVERAGE**-I authorize the County of Sacramento to terminate my participation in the County sponsored medical and/or vision plans. I understand I may be required to show proof of enrollment in another group plan satisfactory to the County in accordance with my Labor Agreement. If approved, coverage shall end the last day of the month in which the request was made, or December 31st for Open Enrollment elections. **Initials:_____ (also sign at "X" below)**

BINDING ARBITRATION-Health plan carriers handle and resolve member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes the Plans use binding arbitration as the final method for resolving all such disputes. As a condition of your membership in the Plan, you must initial next to your plan carrier to indicate that you understand and agree to the following:

WESTERN HEALTH ADVANTAGE (WHA) and SUTTER HEALTH PLUS (SHP)

A. On behalf of myself and my eligible Dependents, I hereby apply for health care coverage offered through my Employer, and agree to be bound by the Group Service Agreement and Evidence of Coverage and Disclosure Form for the plan selected, and this Enrollment/Change Form.

B. Arbitration agreement: I agree and understand that any and all disputes between myself (including any heirs or assigns) and the Plan, 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 submission to 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. The parties, including any heirs or assigns, to this arbitration 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.

WESTERN HEALTH ADVANTAGE-- Initials: _____ (also sign at "X" below) **SUTTER HEALTH PLUS-- Initials: _____ (also sign at "X" below)**

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: _____ (also sign below at "X")

AUTHORIZATION-All information on this form is true and correct; I understand it is the basis on which coverage may be issued under the plan(s). Any dependents listed are my lawful spouse/domestic partner/and children, and are eligible for enrollment as my dependents. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. My signature indicates my acceptance of the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, benefit coverage, and all associated policies.

X EMPLOYEE SIGNATURE_____ Date_____

OFFICE USE ONLY	Rate Change? ☐Y ☐N	Effective Date Of Change	Group Number	Benefits Staff Representative	Date