☐ BS/BS65+ ☐ KP/KPSA ☐ VHMO ☐ DHMO ☐ Census ☐ Billing

City of Bakersfield - Human Resources Division
2018 Retiree Benefit Election/Change Form
For Retirees Eligible for City Health Plans

For HR Use Only:
Annual Enrollment:_____
Retirement Date:_____
Insurance Effective Date:_____

Section 1: Personal Data (Please Print)

Last Name:	First Name:	Middle Name:

Social Security Number: (Required)	Date of Birth:	Check One: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Residential Address: (Required)	City	State:	Zip Code

Personal Email Address:	Personal Phone:

Section 2: Reason for Enrollment/Change

A. Subscriber - Check ALL Boxes that apply

A1. Effective Date:_____

☐ Annual Open Enrollment
☐ Retiree
☐ Loss of Other Group Coverage
☐ Reenrollment / Reinstatement

B. Dependent - Add/Cancel Dependent Coverage
Check All Boxes that apply. Documentation is Required.

B1. ☐ **ADD** ☐ **CANCEL**

Event date:_____

☐ Marriage / Divorce / Legal Separation
☐ New / Term Domestic Partnership (Same Sex or opposite-sex if one partner is at least 62)
☐ Birth / Adoption/Legal Guardianship ☐ Over-Age Dependent
☐ Loss / Gaining of Other Group Coverage

Section 3: Medical Plan Options

Select your medical plan coverage by checking the box next to the plan's coverage level. ***For Dependent Eligibility please see Eligibility Categories below.***

Medical Plan (Includes RX Drug, Mental Health)	Enroll/Cancel	Coverage Level	Monthly Premium (without City subsidy)
Blue Shield PPO Vision – No coverage	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party ☐ Family	$1,073.10 $2,146.06 $3,219.12
Kaiser Permanente HMO (Under 65) Vision – Material Coverage Only through MES, Eye Exam by KP	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party ☐ Family	$1,432.19 $2,864.37 $4,053.09
Kaiser Permanente HMO Deductible (Under 65) Vision – Material Coverage Only through MES, Eye Exam by KP	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party ☐ Family	$1,236.22 $2,472.43 $3,498.48
Blue Shield Medicare Advantage 65+ **Must have Medicare Parts A & B** *****Must also complete Special Enrollment Form***	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party	$364.95 $729.90
Kaiser Senior Advantage Plan **Must have Medicare Parts A & B** *****Must also complete Special Enrollment Form***	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party	$229.69 $459.38

Section 4: Dental Plan Option

Select your dental plan coverage by checking the box next to the plan's coverage level.

Dental Plan	Enroll/Cancel	Coverage Level	Monthly Premium (No Subsidy)
United Concordia DHMO *Concordia Plus 920318-002* **Dental Provider Selection Required**	☐ Enroll ☐ Cancel	☐ Single ☐ Two-Party ☐ Family	$16.17 $29.43 $45.49

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
SPOUSE • Your current legal husband or wife • Domestic Partnership – Same Sex or opposite-sex if one partner is at least 62.	• Copy of official marriage certificate • Declaration of Domestic Partnership with the State of CA.
CHILDREN **Medical & Vision (Kaiser only for Vision): Children between the ages of 19-23 must be enrolled in school and earning 12 or more credits (school transcript required). Dental: Children under the age of 26 may remain on the dental plan.** (Certain unmarried children, if handicapped and incapable of self-support may be eligible beyond age 23, if proper documentation of disability is submitted). The basic definition of "child" is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse.	One of the following: • Copy of birth/adoption certificate • Qualified Medical Child Support Order, or • Court order of legal guardianship

Section 5: Employee/Dependent Information

Enter below information for yourself and any eligible dependent you are enrolling into your medical and dental plans. If enrolling in a dental plan, please be sure to designate a dental provider for yourself and your dependents. You may add additional dependents on a separate sheet of paper. Also, you must attach documentation that supports the relationship for each dependent; required documentation is listed above.

Name (Last, First, M.I.)	Relation-ship	Gender (M/F)	Date Of Birth	Social Security Number (Required)	Medical	Dental	Cancel	Dental Provider Number
	Self	**See Page 1**			☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	

Section 6: Authorization and Signature

1. I declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements.
2. I understand that I am responsible for the tax consequences (including interest & penalties) should the IRS or the City of Bakersfield determine that the benefits requested in this document have a tax consequence.
3. I also certify that the information provided on this form is complete, true & correct to the best of my knowledge.

Applicant Signature Required:

Section 7: Blue Shield PPO Plan Agreements

Disclosure of Personal and Health Information: Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents'' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents'' health information from a healthcare provider, insurer, insurance support organization, health plan or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.

Blue Shield Authorization: I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application within the first 24 months of coverage, my coverage may be canceled, or. Following notice, rescinded.

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

Applicant Signature Required:

Section 8: Kaiser Permanente Benefit Plan Agreement: Kaiser HMO and Kaiser DHMO Plans

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.

Applicant Signature Required:

Section 9: United Concordia Dental Agreement

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Applicant Signature Required:

You may scan and email this completed form to admhrs@bakersfieldcity.us, fax to 661-852-2070 or mail to Human Resources at 1600 Truxtun Ave, Bakersfield, CA 93301. For questions please call 661-326-3773.