Effective Date: _____

GSRMA Health Member Enrollment Form

Group Name: _____

Group Number: _____

☐ New Enrollment
☐ Change Address/Name
☐ Delete Dependent
☐ Open Enrollment
☐ Add Dependent; Qualifying Event _____; Qualifying Event Date _____
☐ COBRA; Qualifying Event _____; Qualifying Event Date _____
☐ Other _____

SELECTED COVERAGE *(Select one. If choosing the HDHP plan, please indicate if you would like the HSA option.)*

HMO	☐ EE only	☐ EE + 1	☐ EE + Family	**Silver PPO**	☐ EE only	☐ EE + 1	☐ EE + Family
EPO	☐ EE only	☐ EE + 1	☐ EE + Family	**Out-of-State PPO**	☐ EE only	☐ EE + 1	☐ EE + Family
Gold PPO	☐ EE only	☐ EE + 1	☐ EE + Family	**HDHP** ☐ *with HSA*	☐ EE only	☐ EE + 1	☐ EE + Family
Other:							

Mid Year Plan Changes Only ***(Note: This section does not apply to open enrollment)*:**

I wish to ADD coverage for ***(check all that apply)*:** ☐ **Employee only** ☐ **Spouse/RDP only** ☐ **Child(ren) only**

I wish to DELETE coverage for ***(check all that apply)*:** ☐ **Employee only** ☐ **Spouse/RDP only** ☐ **Child(ren) only**

EMPLOYEE PERSONAL INFORMATION

Last Name	First Name	M.I.	☐ Male ☐ Female
Social Security Number	Birth Date (mm/dd/yyyy)	Home Phone:	Work Phone:
Residence Street Address (Add mailing address if different)	City	State	Zip Code
Occupation/Title:	Department:	Date of Hire (mm/dd/yyyy)	Hours Worked Per Pay Period / Employee Type: ☐ FT ☐ PT
Marital Status: ☐ Single ☐ Married ☐ Registered Domestic Partner (RDP) ☐ Legally Separated ☐ Divorced	E-Mail Address:		
Medical Group (IPA/MG) # (HMO Only)	Physician Name (First, Last) (HMO Only)	Primary Care Physician (PCP) # (HMO Only)	Is this your current M.D.? (HMO Only) ☐ Yes ☐ No

FAMILY INFORMATION *(Please list all eligible family members to be enrolled. Attach additional sheets if necessary.)*

☐ Spouse ☐ Registered Domestic Partner	Last Name	First Name	M.I.	☐ Male ☐ Female
Social Security Number	Birth Date (mm/dd/yyyy)			
Residence Street Address (No P.O. Box) ☐ Check here if same as employee	City		State	Zip Code
Medical Group (IPA/MG) # (HMO Only)	Physician Name (First, Last) (HMO Only)	Primary Care Physician (PCP) # (HMO Only)	Is this your current M.D.? (HMO Only) ☐ Yes ☐ No	

FAMILY INFORMATION CONTINUED *(Please list all eligible family members to be enrolled. Attach additional sheets if necessary.)*

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Overage Dependent Type ☐ Disabled ☐ Full-Time Student ☐ Over 50% Support	
Residence Street Address (No P.O. Box) ☐ Check here if same as employee	City	State	Zip Code
Medical Group (IPA/MG) # (HMO Only)	Physician Name (First, Last) (HMO Only)	Primary Care Physician (PCP) # (HMO Only)	Is this your current M.D.? (HMO Only) ☐ Yes ☐ No

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Overage Dependent Type ☐ Disabled ☐ Full-Time Student ☐ Over 50% Support	
Residence Street Address (No P.O. Box) ☐ Check here if same as employee	City	State	Zip Code
Medical Group (IPA/MG) # (HMO Only)	Physician Name (First, Last) (HMO Only)	Primary Care Physician (PCP) # (HMO Only)	Is this your current M.D.? (HMO Only) ☐ Yes ☐ No

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Overage Dependent Type ☐ Disabled ☐ Full-Time Student ☐ Over 50% Support	
Residence Street Address (No P.O. Box) ☐ Check here if same as employee	City	State	Zip Code
Medical Group (IPA/MG) # (HMO Only)	Physician Name (First, Last) (HMO Only)	Primary Care Physician (PCP) # (HMO Only)	Is this your current M.D.? (HMO Only) ☐ Yes ☐ No

OTHER HEALTH CARE COVERAGE. REQUIRED INFORMATION FOR PROPER CLAIM PROCESSING.

Please fill out the following information to receive due credit for PREVIOUS COVERAGE, if within 63 days prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate

☐ Self	Name	Name of Other Insurance Carrier			Does it cover Medical? ☐ Yes ☐ No
Prior Coverage Start Date (mm/dd/yyyy)	Prior Coverage End Date (mm/dd/yyyy)	Reason for Ending Coverage	Group # / Policy ID #	Medicare ☐ Part A ☐ Part B	Medicare Claim / HICN #

☐ Spouse ☐ Registered Domestic Partner	Name	Name of Other Insurance Carrier			Is this your dependent's primary coverage? ☐ Yes ☐ No
Does it cover Medical? ☐ Yes ☐ No	Prior Coverage Start Date (mm/dd/yyyy)	Prior Coverage End Date (mm/dd/yyyy)	Reason for Ending Coverage	Group # / Policy ID #	Medicare ☐ Part A ☐ Part B	Medicare Claim / HICN #

☐ Son ☐ Daughter	Name	Name of Other Insurance Carrier				Is this your dependent's primary coverage? ☐ Yes ☐ No
Does it cover Medical? ☐ Yes ☐ No	Prior Coverage Start Date (mm/dd/yyyy)	Prior Coverage End Date (mm/dd/yyyy)	Reason for Ending Coverage	Group # / Policy ID #	Medicare ☐ Part A ☐ Part B	Medicare Claim / HICN #

☐ Son ☐ Daughter	Name	Name of Other Insurance Carrier				Is this your dependent's primary coverage? ☐ Yes ☐ No
Does it cover Medical? ☐ Yes ☐ No	Prior Coverage Start Date (mm/dd/yyyy)	Prior Coverage End Date (mm/dd/yyyy)	Reason for Ending Coverage	Group # / Policy ID #	Medicare ☐ Part A ☐ Part B	Medicare Claim / HICN #
☐ Son ☐ Daughter	Name	Name of Other Insurance Carrier				Is this your dependent's primary coverage? ☐ Yes ☐ No
Does it cover Medical? ☐ Yes ☐ No	Prior Coverage Start Date (mm/dd/yyyy)	Prior Coverage End Date (mm/dd/yyyy)	Reason for Ending Coverage	Group # / Policy ID #	Medicare ☐ Part A ☐ Part B	Medicare Claim / HICN #

DECLINATION OF COVERAGE *(Complete this section if any coverage is to be declined by you are your eligible dependents.)*

I decline Medical coverage for:

☐ Self ☐ Spouse/RDP Only ☐ Other Coverage

☐ Child(ren) Only ☐ Spouse/RDP and Child(ren) Only Insurance Carrier Name _____; or

☐ The Following Dependents Only ☐ Other reasons _____

STOP AND READ CAREFULLY.
SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature _____ **Date** _____

ACCEPTANCE OF COVERAGE *(Signature required.)*

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**: I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and 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 claims subject to ERISA, or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.

Employee Signature	Signature of witness (only required if employee signature is "X")	Date