Effective Date: _____

GSRMA Health Member Enrollment Form

District Name: _____

HEALTH COVERAGES:

☐ New Hire Enrollment ☐ Add or delete Dependent; Qualifying Event _____; Qualifying Event Date _____

☐ Annual Open Enrollment ☐ COBRA; Qualifying Event _____; Qualifying Event Date _____

☐ Name/Address Change ☐ Termination; Qualifying Event _____; Qualifying Event Date _____

☐ Other _____

ANCILLARY COVERAGES:

☐ Delta Dental Enrollment ☐ Add or delete Dependent; Qualifying Event _____ ☐ Other _____

☐ VSP Vision Enrollment ☐ Add or delete Dependent; Qualifying Event _____ ☐ Other _____

SELECTED COVERAGE *(Select one.)*								
Silver PPO	☐ EE only	☐ EE + 1	☐ EE + Family	**HMO**		☐ EE only	☐ EE + 1	☐ EE + Family
Gold PPO	☐ EE only	☐ EE + 1	☐ EE + Family	**EPO**		☐ EE only	☐ EE + 1	☐ EE + Family
Platinum PPO	☐ EE only	☐ EE + 1	☐ EE + Family	**HDHP**	☐ *w/ HSA*	☐ EE only	☐ EE + 1	☐ EE + Family
Gold PPO	☐ EE only	☐ EE + 1	☐ EE + Family	**Bronze PPO**		☐ EE only	☐ EE + 1	☐ EE + Family
Kaiser HMO $15	☐ EE only	☐ EE + 1	☐ EE + Family	**Kaiser HMO $20**		☐ EE only	☐ EE + 1	☐ EE + Family
Dental	☐ Low	☐ Medium	☐ High	**EAP** ☐				
Vision	☐ Option 1 – Plan A	☐ Option 2 – Plan B	☐ Option 3 – Plan B	☐ Option 4 – Plan C	☐ Option 5 – Plan C			

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 INFORMATION

Last Name	First Name		M.I.	☐ Male ☐ Female
Social Security Number	Birth Date (mm/dd/yyyy)	Home Phone:	Cell Phone:	
Mailing Street Address	City		State	Zip Code
Occupation/Title:	Date of Hire (mm/dd/yyyy)		Employee Status: ☐ FT ☐ PT ☐ Early Retiree ☐ Medicare Retiree	

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced

HMO Provider Name (HMO Plans Only)	Primary Care Physician (PCP) # (HMO Only)

SPOUSE INFORMATION

Relation: ☐ Spouse ☐ Domestic Partner	Last Name	First Name, M.I.	☐ Male ☐ Female
Social Security Number		Birth Date (mm/dd/yyyy)	
Mailing Address ☐ Check here if same as employee	City	State	Zip Code
HMO Provider Name (HMO Plans Only)		Primary Care Physician (PCP) # (HMO Only)	

CHILD DEPENDENT INFORMATION

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Disabled? ☐ Yes ☐ No	
Mailing Address ☐ Check here if same as employee	City	State	Zip Code
HMO Provider Name (HMO Plans Only)		Primary Care Physician (PCP) # (HMO Only)	

CHILD DEPENDENT INFORMATION

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Disabled? ☐ Yes ☐ No	
Mailing Address ☐ Check here if same as employee	City	State	Zip Code
HMO Provider Name (HMO Plans Only)		Primary Care Physician (PCP) # (HMO Only)	

CHILD DEPENDENT INFORMATION

☐ Son ☐ Daughter	Last Name	First Name	M.I.
Social Security Number	Birth Date (mm/dd/yyyy)	Disabled? ☐ Yes ☐ No	
Mailing Address ☐ Check here if same as employee	City	State	Zip Code
HMO Provider Name (HMO Plans Only)		Primary Care Physician (PCP) # (HMO Only)	

DECLINATION OF COVERAGE – SIGNATURE REQUIRED – Complete only if declining medical coverage

I understand that I am eligible for medical coverage through my employer. I waive the right to enroll in the medical plan as offered to me by my employer for the following reason (please check one):

☐ I have my own other group coverage
☐ I am covered through my spouse's employer

I understand that by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other coverage).

Employee Signature _____ **Date** _____

ACCEPTANCE OF COVERAGE – SIGNATURE REQUIRED

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.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

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 Blue Cross approval.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, 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 PATIENTPROTECTION 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 BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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 "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Please sign and date this application:

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