

<input type="checkbox"/> Police & Fire <input type="checkbox"/> Federated	Retiree/Survivor Last Name		First Name		M.I.	<input type="checkbox"/> Male	<input type="checkbox"/> Single	
						<input type="checkbox"/> Female	<input type="checkbox"/> Married	
Retirement Date	Street Address			City	State	Zip	<input type="checkbox"/> Domestic Partnership	
Social Security Number (SSN)		Birth Date	Email Address:			Home Phone ( )		
<b>CURRENT Medical Plan:</b> Kaiser Permanente <input type="checkbox"/> Traditional <input type="checkbox"/> Sr. Advantage <input type="checkbox"/> MOOA <input type="checkbox"/> Cost Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO Blue Shield Medicare <input type="checkbox"/> HMO <input type="checkbox"/> PPO UHC <input type="checkbox"/> PacifiCare <input type="checkbox"/> Secure Horizons				Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Family	<b>CURRENT Dental Plan:</b> <input type="checkbox"/> None <input type="checkbox"/> Delta PPO <input type="checkbox"/> DeltaCare USA		<b>CURRENT Vision Plan:</b> <input type="checkbox"/> None <input type="checkbox"/> VSP <input type="checkbox"/> EyeMed <input type="checkbox"/> EyeMed (eyewear)	Coverage Type: <input type="checkbox"/> Member <input type="checkbox"/> Member +1 <input type="checkbox"/> Member +2
<b>NEW Medical Plan: All plans \$25 co-pay</b> <input type="checkbox"/> No Change Kaiser <input type="checkbox"/> Traditional <input type="checkbox"/> Sr. Advantage <input type="checkbox"/> MOOA Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO Blue Shield Medicare <input type="checkbox"/> HMO <input type="checkbox"/> PPO UHC <input type="checkbox"/> PacifiCare <input type="checkbox"/> Group Medicare Advantage <input type="checkbox"/> Terminate Medical			Plan Code	Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Family	<b>NEW Dental Plan:</b> <input type="checkbox"/> No Change <input type="checkbox"/> Delta PPO <input type="checkbox"/> DeltaCare USA <input type="checkbox"/> Terminate Dental		<b>NEW Vision Plan:</b> <input type="checkbox"/> No Change <input type="checkbox"/> VSP <input type="checkbox"/> EyeMed <input type="checkbox"/> EyeMed (eyewear) <input type="checkbox"/> Terminate Vision	Coverage Type: <input type="checkbox"/> Member <input type="checkbox"/> Member +1 <input type="checkbox"/> Member +2

**DEPENDENT INFORMATION**

**This form supersedes all previous enrollment forms, please list ALL dependents. ONLY those listed below will be covered.**

Relation	FTS Y / N	M/F	Last Name	First Name	Birth Date	SSN	Dependent(s): Enter "A" to add or "D" to delete		
							Medical	Dental	Vision
<input type="checkbox"/> Spouse <input type="checkbox"/> DP*	n/a								
Child**									
Child**									
Child**									

\* Domestic Partner (DP)/child: The difference between the family rate and single rate will be taxable to the retiree unless DP and/or child qualifies as a dependent as defined by the IRS.  
 \*\*If your dependent child is 19 years or older, please provide a copy of their full-time student (FTS) status verification if enrolling in dental and/or vision coverage.

**OTHER INSURANCE INFORMATION**

Are you or your dependent(s) covered under another Medical plan? <input type="checkbox"/> No <input type="checkbox"/> <b>Yes, complete the following information:</b> Insurance Company name & telephone number: _____	<b>BLUE SHIELD HMO/POS and SECURE HORIZONS PARTICIPANTS:</b> You must live within the plan's HMO service area in order to enroll in either Blue Shield's HMO or POS plans, or the AARP Medicare Complete (Secure Horizons) plan. You must choose a Primary Care Physician (PCP) when you enroll, otherwise one will be assigned to you.
Are you or your dependent(s) covered under another Dental plan? <input type="checkbox"/> No <input type="checkbox"/> <b>Yes, complete the following information:</b> Insurance Company name & telephone number: _____	Subscriber: _____ PCP & Medical Group: _____ Dependent: _____
Are you or your dependent(s) entitled to benefits under Medicare? <input type="checkbox"/> No <input type="checkbox"/> <b>Yes, submit copy of Medicare card if you have not already.</b> <b>If enrolling or disenrolling from a Medicare Plan, please call the office on (408) 794-1000 or 1(800) 732-6477 to request the necessary forms.</b>	PCP & Medical Group: _____ Dependent: _____ PCP & Medical Group: _____

**KAISER PERMANENTE PARTICIPANTS:** You cannot select a Kaiser Permanente Plan if you live outside of their service area.  
**Kaiser Foundation Health Plan Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligent, 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:** \_\_\_\_\_ **Kaiser Permanente**  **Traditional**  **KPSA**  **MOOA**

**AUTHORIZATION:** I authorize my health plan carrier to release or obtain medical information on myself and covered dependents to or from health care providers/ agencies for the purpose of providing necessary health care services, utilization review, quality assurance, surveys, processing of claims, financial audit or purposes reasonably related to the performance of the agreement or policy. I acknowledge that I have read and understand this application in its entirety. I hereby certify that all information on this form is true and correct.

**Retiree/Survivor Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**For City of San José Department of Retirement Services Use Only**

Group No.:	Coverage Effective Date:	P&F or FED	Agenda Date:
Comment:	<input type="checkbox"/> Active to Retiree	<input type="checkbox"/> Member/Spouse/DP Medicare eligible	<input type="checkbox"/> Date of Death:
	<input type="checkbox"/> Add/Term Dependent:	<input type="checkbox"/> Moved out of the Service Area	<input type="checkbox"/> Date of Divorce:
			<input type="checkbox"/> Other: