

INS 100 (Pg. 1/2) Office of Retirement Services VEBA Insurance Change Form 2024



1

<input type="checkbox"/> Federated	<input type="checkbox"/> Female	<input type="checkbox"/> Married/Domestic Partnership	Is the Member/Survivor covered by Medicare Part A ? Yes No
<input type="checkbox"/> Police & Fire	<input type="checkbox"/> Male	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Is the Member/Survivor covered by Medicare Part B ? Yes No
SSN: _____			
Last Name: _____		Phone : Cell () _____	Home () _____
First Name: _____		DOB: _____	Email: _____
Address: _____			City _____ State _____ Zip _____
Street Addresses <i>only</i> - No P.O. Boxes.			Is this a NEW address ? Yes No

2

Dependent Information		<i>You must list all dependents that will be covered and/or removed from your retirement insurance. Please attach a second page if needed. Do not leave the insurance boxes unanswered. Circle A to Add/keep your dependent on the coverage, or D to Drop your dependent from the coverage.</i>							
Spouse / Domestic Partner:	Last Name , First Name	SSN	DOB	Age	Covered by Medicare A?	Covered by Medicare B?	Medical Insurance	Dental Insurance	Vision Insurance
					Yes or No	Yes or No	A D	A D	A D
Child (CH):					Yes or No	Yes or No	A D	A D	A D
Child (CH):					Yes or No	Yes or No	A D	A D	A D
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3

Current Medical Coverage	Current Dental Coverage	Current Vision Coverage
Current Plan: _____	Current Plan: _____	Current Plan: _____
Coverage Level: _____	Coverage Level: _____	Coverage Level: _____

4

New VEBA Medical Election	New VEBA Dental Election	New Vision Election																																										
<input type="checkbox"/> No Change <input type="checkbox"/> Terminate Coverage	<input type="checkbox"/> No Change <input type="checkbox"/> Terminate	<input type="checkbox"/> No Change <input type="checkbox"/> Terminate																																										
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">Coverage Level (select one)</th> <th style="width:40%;">Kaiser Permanente</th> <th style="width:45%;">Anthem Blue Cross</th> </tr> <tr> <td><input type="checkbox"/> M Only</td> <td>Kaiser VEBA Non-Medicare</td> <td>Anthem VEBA Non-Medicare</td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP</td> <td><input type="checkbox"/> VEBA \$25 Copay HMO</td> <td><input type="checkbox"/> VEBA \$2500 High Deductible Classic PPO</td> </tr> <tr> <td><input type="checkbox"/> M+CH</td> <td>Kaiser VEBA Medicare</td> <td>Anthem VEBA Medicare</td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP+CH</td> <td><input type="checkbox"/> VEBA Senior Advantage*</td> <td><input type="checkbox"/> VEBA Medicare Advantage PPO*</td> </tr> <tr> <td></td> <td>*VEBA Sr. Advantage requires Medicare Part A and Part B</td> <td>* VEBA Medicare Advantage PPO requires Medicare Part A and Part B</td> </tr> </table>	Coverage Level (select one)	Kaiser Permanente	Anthem Blue Cross	<input type="checkbox"/> M Only	Kaiser VEBA Non-Medicare	Anthem VEBA Non-Medicare	<input type="checkbox"/> M+SP/DP	<input type="checkbox"/> VEBA \$25 Copay HMO	<input type="checkbox"/> VEBA \$2500 High Deductible Classic PPO	<input type="checkbox"/> M+CH	Kaiser VEBA Medicare	Anthem VEBA Medicare	<input type="checkbox"/> M+SP/DP+CH	<input type="checkbox"/> VEBA Senior Advantage*	<input type="checkbox"/> VEBA Medicare Advantage PPO*		*VEBA Sr. Advantage requires Medicare Part A and Part B	* VEBA Medicare Advantage PPO requires Medicare Part A and Part B	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;">Dental Plan</th> <th style="width:40%;">DeltaCare VEBA HMO</th> </tr> <tr> <td>Coverage Level (select one)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> M Only</td> <td><input type="checkbox"/> DeltaCare VEBA HMO</td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP</td> <td></td> </tr> <tr> <td><input type="checkbox"/> M+CH</td> <td></td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP+CH</td> <td></td> </tr> </table>	Dental Plan	DeltaCare VEBA HMO	Coverage Level (select one)		<input type="checkbox"/> M Only	<input type="checkbox"/> DeltaCare VEBA HMO	<input type="checkbox"/> M+SP/DP		<input type="checkbox"/> M+CH		<input type="checkbox"/> M+SP/DP+CH		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;">Vision Plans</th> <th style="width:40%;">VSP Signature</th> </tr> <tr> <td>Coverage Level (select one)</td> <td><input type="checkbox"/> VSP Signature</td> </tr> <tr> <td><input type="checkbox"/> M Only</td> <td><input type="checkbox"/> VSP Choice</td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP</td> <td></td> </tr> <tr> <td><input type="checkbox"/> M+CH</td> <td></td> </tr> <tr> <td><input type="checkbox"/> M+SP/DP+CH</td> <td></td> </tr> </table>	Vision Plans	VSP Signature	Coverage Level (select one)	<input type="checkbox"/> VSP Signature	<input type="checkbox"/> M Only	<input type="checkbox"/> VSP Choice	<input type="checkbox"/> M+SP/DP		<input type="checkbox"/> M+CH		<input type="checkbox"/> M+SP/DP+CH	
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Group & Cov Code: _____																																												
Coverage Effective Date: _____																																												
Reviewed: _____																																												
Entered: _____																																												

To enroll in a Medicare Split Plan, you must select a Non-Medicare Plan and a Medicare Plan with the same carrier.

OVER



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Authorization Signature Required

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, qualify 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 under penalty of perjury under the laws of the State of California that all information on this form is true and correct.

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Signature (Required)	Printed Name	Date
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Kaiser Enrollments- Kaiser Foundation Health Plan, Inc., Arbitration Agreement Signature Required.

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.

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Signature Required for all Kaiser Permanente Plans	Printed Name	Date
*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans		

Anthem Blue Cross Enrollment Signature

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

7



Signature Required for all Anthem BlueCross Plans	Printed Name	Date
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8

Are you or your dependent(s) covered under another <u>Medical</u> Plan?	NO	YES	Provide Insurance Company Name and Phone Number below
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9

Are you or your dependent(s) covered under another <u>Dental</u> Plan?	NO	YES	Provide Insurance Company Name and Phone Number below
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