Office of Retirement Services COBRA Insurance Election Form

1

RETIREE INFORMATION: ☐ Federated ☐ Police & Fire Retirement Date: _____

2

COBRA ENROLLEE (NOT Retiree) Information: ☐ Female ☐ Male ☐ Single ☐ Divorced ☐ Married/Domestic Partnership

SSN: _____ **DOB:** _____

Last Name: _____ **Phone:** **Cell ( )** _____ **Home ( )** _____

First Name: _____ **E-mail:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

*Street Addresses **only** - No P.O. Boxes.*

You may only elect COBRA coverage for the types of insurance (medical, dental, vision) for which you have just lost coverage.

3

Medical Insurance		
Coverage Level (select one)	**Kaiser Permanente**	**Anthem BlueCross**
	Non-Medicare Plans	**Non-Medicare Plans**
☐ Member Only	☐ $25 Copay HMO	☐ $20 Copay Select HMO
☐ Member+Child	☐ $1500 Deductible HMO	☐ $1500 Deductible Select HMO
	☐ $3,000 High Deductible HMO	☐ $100 Deductible Select PPO
		☐ $100 Deductible Classic PPO
		☐ $2,500 High Deductible Classic PPO
	Medicare Plan	**Medicare Plans**
	☐ Senior Advantage	☐ Medicare Advantage HMO
		☐ Medicare Advantage PPO

Dental Insurance	
Coverage Level (select one)	**Dental Plans**
☐ Member Only	☐ Delta Care HMO
☐ Member+Child	☐ Delta Dental PPO

Vision Insurance	
Coverage Level (select one)	**Vision Plans**
☐ Member Only	☐ **VSP Signature**
☐ Member+Child	☐ **VSP Choice**

For Office Use Only

Group

& Cov Code: **COBRA**

Coverage Effective Date:

Reviewed:

Entered:

4

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 that all information on this form is true and correct.

Enrollee (NOT Retiree) Signature (Required) Printed Name Date

OVER

INS 100 (Pg. 1/2) CITY OF SAN JOSE CAPITAL OF SILICON VALLEY **Office of Retirement Services Retiree Insurance Election Form**

Enrollee Name (Printed):

Kaiser Enrollments- Kaiser Foundation Health Plan, Inc., Arbitration Agreement Signature Required.

4

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.

➡ _____

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

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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.

➡ _____

Signature Required for all Anthem BlueCross Plans Printed Name Date

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➡ **Anthem HMO Enrollments:** You must select your Primary Care Physician (PCP). Please list you and your dependents' names along with the name of their PCP name.

Name	Primary Care Physician	Name	Primary Care Physician
Name	Primary Care Physician	Name	Primary Care Physician

7 ➡ Are you or your dependent(s) covered under another Medical Plan? NO YES Provide Insurance Company Name and Phone Number below

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