

# CITY OF CHICO – APPLICATION FOR BENEFITS

## ACTIVE EMPLOYEES

Effective Date: \_\_\_\_\_

TYPE OF TRANSACTION									
<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Termination of Coverage		<input type="checkbox"/> Open Enrollment (Check All That Apply):		<input type="checkbox"/> Change in Medical Plan		<input type="checkbox"/> Add/Remove Dependents	
<input type="checkbox"/> Mid-Year Plan Changes (Check All That Apply):		<input type="checkbox"/> Add Dependent – Qualifying Event: _____		Qualifying Event Date: _____		<input type="checkbox"/> Delete Dependent – Qualifying Event: _____		Qualifying Event Date: _____	
<input type="checkbox"/> Change/Correction of Name				<input type="checkbox"/> Change/Correction of Date of Birth					
EMPLOYEE INFORMATION									
Last Name:			First Name:			Middle Name:		Date of Birth:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:			Primary Phone:		Secondary Phone:			
Mailing Address:				City:		State:	Zip:		
Physical Address: (If Different)				City:		State:	Zip:		
Occupation/Job Title:			Department:		Hire Date:		Hours per Pay Period:		
Medicare: <input type="checkbox"/> None <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim/HICN #:		Email Address:						
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Registered Domestic Partner		<input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced		
ENROLLMENT									
SELF									
Coverage: Medical:		<input type="checkbox"/> PPO 90/10	<input type="checkbox"/> PPO 80/20	<input type="checkbox"/> EPO	<input type="checkbox"/> HDHP	<input type="checkbox"/> Opt Out of Medical			
Dental & Vision:		<input checked="" type="checkbox"/> Automatic Coverage							
SPOUSE / REGISTERED DOMESTIC PARTNER									
Last Name:			First Name:			Date of Birth:			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:			Marriage/Divorce Date:					
Physical Address: (If Different)				City:		State:	Zip:		
Medicare: <input type="checkbox"/> None <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Medicare Claim/HICN #:		Spouse Phone:					
Coverage Elected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Coverage Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
CHILD(REN)									
Last Name:			First Name:			Date of Birth:			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:			Coverage Type: <input type="checkbox"/> Under Age 26 <input type="checkbox"/> Disabled					
Physical Address: (If Different)				City:		State:	Zip:		
Medicare: <input type="checkbox"/> None <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Medicare Claim/HICN #:		Dependent Type: <input type="checkbox"/> Natural Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted Child					
Coverage Elected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Coverage Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number:			Coverage Type: <input type="checkbox"/> Under Age 26 <input type="checkbox"/> Disabled					
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Coverage Elected: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Coverage Declined: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision					

# CITY OF CHICO – APPLICATION FOR BENEFITS

## ACTIVE EMPLOYEES

EMPLOYEE INFORMATION			
Last Name:	First Name:	Social Security Number:	Date of Birth:

DECLINATIONS OF COVERAGE										
<b>STOP AND READ CAREFULLY. SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.</b>										
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).										
<b>Coverage(s) Declined:</b>	<table style="width: 100%;"> <tr> <td style="width: 25%;"><b>Medical -</b></td> <td><input type="checkbox"/> Myself</td> <td><input type="checkbox"/> Dependent(s)</td> </tr> <tr> <td><b>Dental -</b></td> <td><input type="checkbox"/> Myself</td> <td><input type="checkbox"/> Dependent(s)</td> </tr> <tr> <td><b>Vision -</b></td> <td><input type="checkbox"/> Myself</td> <td><input type="checkbox"/> Dependent(s)</td> </tr> </table>	<b>Medical -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)	<b>Dental -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)	<b>Vision -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)
<b>Medical -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)								
<b>Dental -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)								
<b>Vision -</b>	<input type="checkbox"/> Myself	<input type="checkbox"/> 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.										
Signature: _____	Date: _____									

ACCEPTANCE OF COVERAGE	
<b>CSAC-EIA HEALTH</b>	
<p>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.</p> <p>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.. 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.</p>	
<b>DELTA DENTAL</b>	
<p><b>Active Employees:</b> I understand that I may be required by the employer to pay for these benefits. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.</p>	

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HUMAN RESOURCES USE ONLY																			
<b>Plan Elections:</b>	<table style="width: 100%;"> <tr> <td style="width: 15%;"><b>Medical</b></td> <td><input type="checkbox"/> Single</td> <td><input type="checkbox"/> Double</td> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> None</td> <td>Plan: _____</td> </tr> <tr> <td><b>Dental</b></td> <td><input type="checkbox"/> Single</td> <td><input type="checkbox"/> Double</td> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> None</td> <td></td> </tr> <tr> <td><b>Vision</b></td> <td><input type="checkbox"/> Single</td> <td><input type="checkbox"/> Double</td> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> None</td> <td></td> </tr> </table>	<b>Medical</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None	Plan: _____	<b>Dental</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None		<b>Vision</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None	
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<b>Vision</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None															
Entered into IFAS: _____	Provider System Updated: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <b>Date/Initials:</b> _____																		