

CITY OF CHICO – APPLICATION FOR BENEFITS RETIREE & COBRA COVERAGE

EMPLOYEE INFORMATION

Last Name:	First Name:	Social Security Number:	Date of Birth:
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DECLINATIONS OF COVERAGE

**STOP AND READ CAREFULLY. SIGN THIS SECTION ONLY IF DECLINING COVERAGE.
IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.**

The available coverages have been explained to me by the City of Chico. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

Coverage(s) Declined:

Medical -	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)
Dental -	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)
Vision -	<input type="checkbox"/> Myself	<input type="checkbox"/> Dependent(s)

By declining coverage I acknowledge that I may have not future rights to enroll in coverage and that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event if I do have future rights to enroll. 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

CSAC-EIA HEALTH

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. 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.

Signature: _____ **Date:** _____

HUMAN RESOURCES USE ONLY

Plan Elections:

Medical	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None	Plan: _____
Dental	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None	
Vision	<input type="checkbox"/> Single	<input type="checkbox"/> Double	<input type="checkbox"/> Family	<input type="checkbox"/> None	

Provider System Updated: Dental Vision Medical **Date/Initials:** _____