**CITY OF CHICO**

# HEALTH INSURANCE ELECTION FORM

☐ New Enrollment
☐ Qualifying Event
Event Type: _____
Event Date: _____

**Insurance Effective Date:** _____

## EMPLOYEE INFORMATION

| Last Name: | First Name: | Middle Name: | Date of Birth: |
|---|---|---|---|

| Sex: ❑ Male ❑ Female | Social Security Number: | Primary Phone: | Secondary Phone: |
|---|---|---|---|

| Mailing Address: | City: | State: | Zip: |
|---|---|---|---|

| Medicare: ❑ None ❑ Part A ❑ Part B | Medicare Claim/HICN #: | Email Address: |
|---|---|---|

Marital Status: ❑ Single ❑ Married ❑ Registered Domestic Partner ❑ Legally Separated ❑ Divorced

## ENROLLMENT

### SELF

**Coverage:** **Medical:** ❑ PPO 90/10 ❑ PPO 80/20 ❑ EPO ❑ HDHP ❑ Decline Medical Coverage
**Dental:** ❑ Elect Coverage ❑ Decline Coverage **Vision:** ❑ Elect Coverage ❑ Decline Coverage

### SPOUSE / REGISTERED DOMESTIC PARTNER

| Last Name: | First Name: | Date of Birth: |
|---|---|---|

| Sex: ❑ Male ❑ Female | Social Security Number: | Marriage Date: |
|---|---|---|

| Medicare: ❑ None ❑ Part A ❑ Part B | Medicare Claim/HICN #: | Spouse Phone: |
|---|---|---|

**Coverage Elected:** ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

### CHILD(REN)

| Last Name: | First Name: | Date of Birth: |
|---|---|---|

| Sex: ❑ Male ❑ Female | Social Security Number: | Coverage Type: ❑ Under Age 26 ❑ Disabled |
|---|---|---|

| Medicare: ❑ None ❑ Part A ❑ Part B | Medicare Claim/HICN #: | Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child |
|---|---|---|

**Coverage Elected**: ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

| Last Name: | First Name: | Date of Birth: |
|---|---|---|

| Sex: ❑ Male ❑ Female | Social Security Number: | Coverage Type: ❑ Under Age 26 ❑ Disabled |
|---|---|---|

| Medicare: ❑ None ❑ Part A ❑ Part B | Medicare Claim/HICN #: | Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child |
|---|---|---|

**Coverage Elected:** ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

| Last Name: | First Name: | Date of Birth: |
|---|---|---|

| Sex: ❑ Male ❑ Female | Social Security Number: | Coverage Type: ❑ Under Age 26 ❑ Disabled |
|---|---|---|

| Medicare: ❑ None ❑ Part A ❑ Part B | Medicare Claim/HICN #: | Dependent Type: ❑ Natural Child ❑ Step-Child ❑ Adopted Child |
|---|---|---|

**Coverage Elected:** ❑ Medical ❑ Dental ❑ Vision **Coverage Declined:** ❑ Medical ❑ Dental ❑ Vision

**PLEASE READ CAREFULLY the terms contained on the reverse of this application. Your signature is required to complete an application for benefits.**

→→

**HUMAN RESOURCES USE ONLY**

| | | | |
|---|---|---|---|
| **Plan Elections:** | **Medical** | ☐ Single ☐ Double ☐ Family ☐ None Plan: _____ | ☐ **Entered into Payroll** |
| | **Dental** | ☐ Single ☐ Double ☐ Family ☐ None | ☐ **BCC Updated** |
| | **Vision** | ☐ Single ☐ Double ☐ Family ☐ None | **Date/Initials:** _____ |

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**DEDUCTION AUTHORIZATION**: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.
**NON-PARTICIPATING PROVIDER**: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
**HIV TESTING PROHIBITED**: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
**EFFECTIVE DATE**: The effective date of coverage is subject to Anthem Blue Cross approval.
**COBRA/CAL-COBRA CONTINUATION COVERAGE**
You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice.
If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end.
If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end. **Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.**

**W–9 Certification Language**
I certify each Social Security number listed on this application is correct.

**REQUIREMENT FOR BINDING ARBITRATION**
ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, 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 BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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 "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

**Signature:** _____ **Date:** _____