



Effective Date: 01/01/2016

Medical and Dental Enrollment Form

Group Name: Otay Water District
County: _____

- Open Enrollment Add Dependent; Qualifying Event _____; Qualifying Event Date _____
 New Enrollment Other _____
 Delete Dependent

SELECTED COVERAGE <i>(Select one)</i>			
<p style="text-align: center;">Medical</p> <p>Note: HMO and EPO Plans are not available for Medicare eligible Retirees or participants HMO Plan is not available for out-of-state participants.</p>	<p style="text-align: center;">Dental Group (Select One)</p> <p><input type="checkbox"/> Group # 00001- ACTIVE EMPLOYEE</p> <p><input type="checkbox"/> Group # 00002- RETIREE</p> <p><input type="checkbox"/> Group # 00003- BOARD</p> <p><input type="checkbox"/> Group # 09001- COBRA</p>		
<p>Access + HMO 15 <input type="checkbox"/> EE only <input type="checkbox"/> EE + 1 <input type="checkbox"/> EE + Family</p>	<p style="text-align: center;">Dental Coverage for Employee Only is required. (Retiree eligibility is based on Retiree Tier)</p>		
<p>EPO <input type="checkbox"/> EE only <input type="checkbox"/> EE + 1 <input type="checkbox"/> EE + Family</p>	<p>Dental <input type="checkbox"/> EE only <input type="checkbox"/> EE + 1 <input type="checkbox"/> EE + Family</p>		
<p>Gold PPO <input type="checkbox"/> EE only <input type="checkbox"/> EE + 1 <input type="checkbox"/> EE + Family</p>			
<p><input type="checkbox"/> Decline Medical Coverage (Please complete the Declination of Coverage Section and attach necessary documentation)</p>			
EMPLOYEE INFORMATION			
Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Home Phone:	Work Phone:
Residence Street Address (No P.O. Box)	City	State	Zip Code
Mailing Street Address	City	State	Zip Code
Occupation/Title:	Date of Hire (mm/dd/yyyy)	Hours Worked Per Pay Period	Employee Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Non-Medicare Retiree <input type="checkbox"/> Medicare Retiree
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner (RDP)* <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare: <input type="checkbox"/> Part A <small>(if applicable)</small> <input type="checkbox"/> Part B	Medicare Claim / HICN #	E-Mail Address:	

***Registered Domestic Partner (RDP). You must attach proof of Domestic Partnership Registration as defined under Section 297 and 299.2 of the California Family Code.**

DEPENDENT INFORMATION (Please list all eligible family members to be enrolled. Attach additional sheets if necessary.)

<input type="checkbox"/> Spouse <input type="checkbox"/> RDP*	Add: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Delete: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Last Name	First Name	M.I.
<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address (No P.O. Box) <input type="checkbox"/> Check here if same as employee		City	State	Zip Code
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Add: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Delete: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Last Name	First Name	M.I.
Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Under age 26	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address (No P.O. Box) <input type="checkbox"/> Check here if same as employee		City	State	Zip Code
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Add: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Delete: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Last Name	First Name	M.I.
Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Under age 26	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address (No P.O. Box) <input type="checkbox"/> Check here if same as employee		City	State	Zip Code
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Add: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Delete: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Last Name	First Name	M.I.
Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Under age 26	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address (No P.O. Box) <input type="checkbox"/> Check here if same as employee		City	State	Zip Code
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Add: <input type="checkbox"/> Medical <input type="checkbox"/> Dental Delete: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Last Name	First Name	M.I.
Social Security Number (Required)	Birth Date (mm/dd/yyyy)	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Under age 26	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address (No P.O. Box) <input type="checkbox"/> Check here if same as employee		City	State	Zip Code
Medical Group (IPA/MG) # <small>(Required for HMO Only)</small>	Physician Name (First, Last) <small>(Required for HMO Only)</small>	Primary Care Physician (PCP) # <small>(Required for HMO Only)</small>	Is this your current PCP? (HMO Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	

*Registered Domestic Partner (RDP). You must attach proof of Domestic Partnership Registration as defined under Section 297 and 299.2 of the California Family Code.

DECLINATION OF COVERAGE (Complete this section if medical coverage is to be declined by you or your eligible dependents.)

I decline Medical coverage for:

- Self Spouse/RDP
 Child(ren) Spouse/RDP and Child(ren)

You may elect to waive coverage if you or your dependents are covered by another group health insurance plan. Please attach proof of medical insurance coverage (i.e. insurance ID card) only if you are waiving coverage for yourself.

Reason for Declination:

Other Coverage: Insurance Carrier Name: _____

Other Reasons: _____

List Dependent Name(s) Waiving Coverage: _____

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

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).

By declining coverage I acknowledge that my dependents and I will 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.

Employee Signature _____ Date _____

If you are enrolling yourself in the medical plan, you must also sign under the "Acceptance of Coverage" section below.

ACCEPTANCE OF COVERAGE (Required by Blue Shield)

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.

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 dues.

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 HIV tests 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 Blue Shield of California and/or the California State Association of Counties Excess Insurance Authority approval.

REQUIREMENT FOR BINDING ARBITRATION The following provision does not apply to class actions: **IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY, BLUE SHIELD OF CALIFORNIA REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES 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, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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 provided by California law, 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. THIS MEANS THAT YOU AND BLUE OF CALIFORNIA ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

I hereby authorize Otay Water District to take my Medical and/or Dental premium deductions on a (PLEASE SELECT ONE):
 PRE-TAX BASIS OR POST-TAX BASIS
(If covering Domestic Partner, Post-Tax is required, per IRS guidelines.)

I acknowledge that each dependent listed in the Enrollment Form meets the definition of dependent per the District's health plan rules and I understand that any falsification, omission, or misrepresentation of information will be considered fraud and could lead to disciplinary action, cancellation of the plan, and other necessary actions deemed appropriate by the District. I further acknowledge that I will be required to and, by my signature below, hereby agree to reimburse the District for any insurance coverage expenses that the District incurred for ineligible dependent coverage, including, but not limited to, via deduction from my wages (for active employees) or civil action. I further agree to notify the District within 31 calendar days if any of my eligible dependents become ineligible (e.g. legal separation, divorce, death, or over-age dependent). I further agree to provide proof of eligibility upon request.

I further authorize the exchange of information necessary to provide the benefits afforded by the Plan.

Please sign and date this application:

Signature	Date
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Copy Sent to Providers: ____ IG Input: ____ Notify Payroll ____