

**Medical / Dental / Life / Vision Enrollment Application**

Please select one:  New Hire Enrollment  New Renewal Enrollment  New COBRA Enrollment

**A. PERSONAL INFORMATION**

Application must be **COMPLETED** in FULL, SIGNED and DATED for processing

Name of Company			Employer Phone #			Employee Job Title			Full-time Employment Date		
Sex <input type="checkbox"/> M <input type="checkbox"/> F			Status <input type="checkbox"/> Married <input type="checkbox"/> Single <i>(Note: If you or any of your dependents are <u>not</u> enrolling, you must also complete and sign the waiver section on back.)</i> <input type="checkbox"/> Domestic Partner								
Employee Last Name						Employee Social Security Number					
Employee First Name						Date of Birth MO DAY YEAR			Group Number		
Residence Address (required)				Apt #		City		State		Zip Code	
Home Telephone ( )		Email Address				Mailing Address <i>(if different from above)</i>					

**B. MEDICAL BENEFIT** (select one plan only)

<b>HMO (Kaiser Permanente)</b>		<b>HMO (Western Health)</b>		<b>PPO (Health Net)</b>			<b>Indemnity (Health Net)</b>			
<input type="checkbox"/> HMO 2200	<input type="checkbox"/> HMO 2600	<input type="checkbox"/> HMO 1800	<input type="checkbox"/> HMO 2800B	<input type="checkbox"/> PPO 2500	<input type="checkbox"/> PPO 3500	<input type="checkbox"/> PPO 4500	<input type="checkbox"/> Flex Net	<small>Only available if Out of State and not eligible for PPO plans. Not an HSA-compatible plan.</small>		

**IMPORTANT "OPT OUT" NOTICE ABOUT THE PRIVACY OF YOUR INFORMATION:** If your Employer elects to automatically open, and possibly fund, Health Savings Accounts for each Employee, we will provide Bancorp with personal information about you necessary for Bancorp to open and maintain an HSA in your name. If you DO NOT want that information shared with Bancorp, you MUST indicate that by checking the "Opt Out" box below. Checking the "Opt Out" box will not allow Bancorp to automatically open your HSA and may hinder your Employer's ability to fund said account.  **OPT OUT: I DO NOT want my information disclosed to or used by Bancorp**

**C. OPTIONAL BENEFITS** — Ask your health plan administrator if any of the optional benefits below are being offered by your employer

Sections A, D & E must be completed for life coverage

<b>Life Insurance</b>	
Full Name of Beneficiary	Date of Birth for Beneficiary
Relationship of Beneficiary	Life Amount
<b>Dental Coverage</b>	
<input type="checkbox"/> Dental Plan 1000 <sup>†</sup>	<input type="checkbox"/> Dental Plan 3000 <sup>†</sup>
<input type="checkbox"/> Dental Plan 3500	<input type="checkbox"/> Dental Plan 4000
<input type="checkbox"/> Voluntary Dental 3000 <sup>†</sup>	<input type="checkbox"/> Dental Plan 5000
<input type="checkbox"/> Check if dentist chosen is current provider	
<input type="checkbox"/> Check if you would like a dentist assigned	
<sup>†</sup> If you choose plans 1000 or 3000, you must select a dentist:	Dentist: ID#:
<b>Vision Coverage</b>	
<input type="checkbox"/> Vision (discount plan)	<input type="checkbox"/> Voluntary Vision (additional charge)
<b>Premium Only Plan (P.O.P.)</b>	
<input type="checkbox"/> I want my portion of eligible insurance premiums paid on a pre-tax basis	

**D. ENROLLMENT INFORMATION** — For additional dependent enrollment, complete sections A & D on a separate application.

Complete this section ONLY if you are electing medical, dental and/or vision for yourself and dependents

	Employee	Spouse	Child	Child	Child
Last Name	<input type="checkbox"/> Life only				
First Name					
Relationship to Employee		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
Social Security No.					
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		/ /	/ /	/ /	/ /
Primary Care Physician*					
Physician ID# & City					
Current Patient of PCP?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling For?	<input type="checkbox"/> Med <input type="checkbox"/> Dent <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent <sup>†</sup> <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent <sup>†</sup> <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent <sup>†</sup> <input type="checkbox"/> Vision	<input type="checkbox"/> Med <input type="checkbox"/> Dent <sup>†</sup> <input type="checkbox"/> Vision

Check here if you would like your Health Care Service Plan to assign you a Primary Care Physician.

\* Please be sure to verify that your PCP is contracted with your selected carrier prior to enrolling. New Hire applications added to existing groups will automatically be assigned a PCP if one is not chosen or PCP is not contracted with the selected health plan. For Kaiser Permanente enrollees, no PCP selection is required.

<sup>†</sup> Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under Age 3).

**E. YOUR LEGAL ACKNOWLEDGEMENT (Read, sign and date where indicated)**

By submitting this signed application, I agree and understand that the health plan I have chosen through the HSA California® program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the HSA California program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize HSA California and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

**I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application.**

- I am either actively, permanently working for the employer and considered eligible by my employer because I work either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partners.

I understand that the preceding statements are subject to audit at any time and agree to provide HSA California with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all HSA California benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through HSA California program providers thereafter.

I understand that any persons, business or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements listed on page 4 of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

**HEALTH NET ENROLLEES:**

**BINDING ARBITRATION AGREEMENT:** Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

**KAISER FOUNDATION HEALTH PLAN ENROLLEES:**

**Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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.

**WESTERN HEALTH ADVANTAGE ENROLLEES:**

**Arbitration Agreement:** I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including 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 Small Claims Court cases and claims subject to ERISA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, to this agreement 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 binding arbitration.

Employee SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE:

Print Name

Date:



My signature acknowledges both the applicable arbitration disclosure of the health plan I selected in Section B and my decision to enroll in the medical, dental, life or vision coverage that I selected in Section C.

<b>COBRA Applicants:</b> Please check COBRA type: <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA	<b>Indicate Qualifying Event:</b> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Child no longer eligible <input type="checkbox"/> Reduction of hours <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Medicare entitlement <input type="checkbox"/> Death of employee	<b>Date of Qualifying Event</b> <input type="text"/>
		<input type="text"/>

**Employer/HSA California Use Only**

New Group-employee    New Hire    Renewal   Effective Date:

**F. FULL-TIME STUDENT VERIFICATION**

If you wish to include a dependent between the ages of 19 and 24 under your medical and/or dental coverage, your dependent must meet the following eligibility requirements:

- Unmarried or not involved in a domestic partnership
- Financially dependent upon the Employee per IRS guidelines
- Enrolled as a full-time student (minimum 12 units) in a qualified college, university, vocational or secondary school

This form must be completed and signed by the employee. Failure to complete and submit this verification may result in the denial of service/claims submitted on behalf of the dependent.

Student's Name		Date of Birth
Name of School	Address	
Employee Signature		Date

**Medical / Dental Waiver**

Complete this form only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.**

**A. Personal Information**

Name of Company		Employer Phone Number
Employee Last Name		Employee Social Security Number
Employee First Name		Group Number

**B. Type of Waiver**

I have been offered coverage by my employer, but at this time I wish to **DECLINE** coverage as follows:

- 1) **Medical for:**  Myself and dependents  Spouse/Domestic Partner  Child(ren)
- 2) **Dental for:**  Myself and dependents  Spouse/Domestic Partner  Child(ren)

**C. Reason**

Required only if employee waiving coverage—not required if waiving coverage for dependents only


- 1) **Reason waiving Medical:**
- Other group coverage Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: \_\_\_\_\_ (explanation required)
- 2) **Reason waiving Dental:**
- Other group coverage Carrier Name: \_\_\_\_\_ Group # \_\_\_\_\_
- Medicare
- Medi-cal
- Individual Policy
- Other Reason: \_\_\_\_\_ (explanation required)

**D. Signature**

I understand that by failing to elect coverage now, HSA California® can impose up to a 12 month period of exclusion should I request coverage at a later date.

I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

*This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.*

Employee <b>SIGN HERE TO WAIVE COVERAGE:</b> 	Date
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## Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that <b>MUST</b> be met:
<b>New Spouse</b>	<p>If marriage occurred before the 16th of the month, coverage begins on date of marriage<sup>†</sup></p> <p>If marriage occurred on the 16th of the month or after, coverage begins on the first of month <u>following</u> date of marriage</p>	<ul style="list-style-type: none"> <li>■ New spouse must be legally married to the employee</li> </ul>
<b>New Baby, Adopted Child, New Stepchild, Non-Temporary Legal Ward, and Dependent Children</b>	<p>If birth/date of placement occurred before the 16th of the month, coverage begins on the date of their birth/placement<sup>†</sup></p> <p>If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the <u>following</u> month</p>	<ul style="list-style-type: none"> <li>■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee</li> <li>■ Financially dependent upon the employee per IRS guidelines</li> <li>■ Unmarried or not involved in a domestic partnership</li> <li>■ Under age 19—unless disabled, disability occurring prior to age 25—or a full-time student and under age 25</li> </ul> <p><b>Please note:</b> A dependent child enrolled as a full-time student will not lose medical coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. Physician Certification will be required and must be submitted within 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school.</p> <p><b>Disabled Dependents:</b> Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <div style="background-color: black; color: white; text-align: center; padding: 5px; font-weight: bold;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</div>
<b>Domestic Partner</b>	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a domestic partner will require a state-stamped copy of the Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships.</p>	<p><u>For a Domestic Partner to qualify, Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> <li>■ Share a common residence</li> <li>■ Neither is married under either statutory, common law or part of another domestic partnership</li> <li>■ Both be 18 years of age or older</li> <li>■ Share an intimate and committed relationship</li> <li>■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship</li> <li>■ Both be mentally competent</li> <li>■ Not related by blood to a degree of closeness that would prohibit marriage in this state</li> <li>■ Agree to notify HSA California® immediately upon termination of domestic partnership</li> </ul> <p>Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership.</p> <div style="background-color: black; color: white; text-align: center; padding: 5px; font-weight: bold;">Employee and Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</div>
<b>Children of Domestic Partner</b>	See Domestic Partner above	<p><u>Domestic Partner must meet requirements listed above, and Children of Domestic Partner must be:</u></p> <ul style="list-style-type: none"> <li>■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee or domestic partner</li> <li>■ Financially dependent upon the employee or domestic partner</li> <li>■ Unmarried or not involved in a domestic partnership</li> <li>■ Under age 19—unless disabled, disability occurring prior to age 25—or a full-time student and under age 25</li> </ul> <p><b>Please note:</b> A dependent child enrolled as a full-time student will not lose medical coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. Physician Certification will be required and must be submitted within 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school.</p> <p><b>Disabled Dependents:</b> Dependents who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <div style="background-color: black; color: white; text-align: center; padding: 5px; font-weight: bold;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</div>

<sup>†</sup> Although coverage may become effective at any time of the month based on date of marriage/domestic partnership/birth/adoption, full premium for increased coverage will be assessed as described in the Effective Dates column located above.