COUNTY OF SAN MATEO
HUMAN RESOURCES DEPARTMENT
EMPLOYEE BENEFITS DIVISION

PHONE: (650) 363-1919
FAX: (650) 599-1573
EMAIL: Benefits@smcgov.org

RETIREE OPEN ENROLLMENT CHANGE FORM

PLEASE SUBMIT THIS FORM ONLY IF MAKING CHANGES

E-Mail: benefits@smcgov.org | Fax: 650-599-1573

- **SENDING VIA USPS MAIL MAY CREATE ENROLLMENT DELAYS. Please email or fax ONLY if making changes**
- **DO NOT** complete and return this form if you are **not** making changes.
- All current benefits will roll over and an enrollment form is not required.
- All open enrollment changes must be submitted to our office on this form **no later than November 10, 2022.**
- If changing plans or adding new Medicare dependent: Medicare recipients must complete all information requested below and submit the change form **with a Copy of Medicare Card(s)**
- All changes effective **JANUARY 1, 2023**

1. RETIREE'S CURRENT INFORMATION - REQUIRED

LAST NAME | FIRST NAME | MIDDLE INITIAL

SOCIAL SECURITY # | DATE OF BIRTH | GENDER

CELLPHONE NUMBER | HOME NUMBER | EMAIL ADDRESS

RETIREE MEDICARE INFORMATION - COMPLETE ONLY IF ENROLLING OR CHANGING MEDICARE MEDICAL PLAN

MEDICARE NUMBER | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

☐ CHECK BOX IF ADDRESS HAS CHANGED

Permanent Address

STREET ADDRESS **NO P.O. BOXES**

CITY | STATE | ZIP

2. DO YOU WANT TO CANCEL YOUR BENEFITS?

Benefit Type ☐ ALL ☐ MEDICAL ☐ DENTAL ☐ VISION

IF YOU CANCEL MEDICAL COVERAGE, YOU ARE PERMANENTLY WAIVING YOUR RIGHTS TO THE COUNTY'S GROUP PLAN AND WILL NOT BE ELIGIBLE TO RE-ENROLL; MEDICAL COVERAGE MUST BE CONTINUOUS.

3. DO YOU WANT TO DROP DEPENDENTS? (check the box to enter dependent's information)

☐ LAST NAME / FIRST NAME	CANCEL: ☐ ALL ☐ MEDICAL ☐ DENTAL ☐ VISION RELATIONSHIP: ☐ CHILD ☐ SPOUSE/DOMESTIC PARTNER(DP)
☐ LAST NAME / FIRST NAME	CANCEL: ☐ ALL ☐ MEDICAL ☐ DENTAL ☐ VISION RELATIONSHIP: ☐ CHILD
☐ LAST NAME / FIRST NAME	CANCEL: ☐ ALL ☐ MEDICAL ☐ DENTAL ☐ VISION RELATIONSHIP: ☐ CHILD

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4. ENROLL/MAKE CHANGES TO BENEFITS

To change, mark "cancel" next to your current plan and mark "enroll" next to the new plan.

4a. VISION PLAN Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from Jan. – Dec. 2023.

Action	Provider/Plan	Coverage
☐ ENROLL ☐ CANCEL	**Voluntary Vision Service**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ CANCEL	**VSP Mgt/Rep**	Closed to new enrollees

4b. DENTAL PLAN Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from Jan. – Dec. 2023.

Action	Provider/Plan	Coverage
☐ ENROLL ☐ CANCEL	**Voluntary Cigna DHMO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Voluntary Cigna DPPO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ CANCEL	**Cigna DHMO Mgt/Rep**	Closed to new enrollees
☐ CANCEL	**Cigna DPPO Mgt/Rep**	Closed to new enrollees

If you are not currently enrolled in a medical plan, you are not able to add medical coverage.
Changes to your plan can only happen if you are already enrolled in a medial plan with the County of San Mateo.

4c. MEDICAL PLANS FOR RETIREES UNDER 65 YEARS OLD:

☐ ENROLL ☐ CANCEL	**Aetna HMO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Aetna AVN**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Aetna OAMC PPO ($200)**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Aetna OAMC PPO ($300)**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Aetna PPO HDHP**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Kaiser HMO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Kaiser HDHP**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Alt Health Plan**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Op Eng. Kaiser**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Op Eng. PPO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family

4d. MEDICAL PLANS ONLY AVAILABLE IF CURRENTLY ENROLLED IN MEDICARE:

☐ ENROLL ☐ CANCEL	**Aetna Medicare PPO**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Kaiser Senior Advantage**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family
☐ ENROLL ☐ CANCEL	**Alt Health Plan**	☐ Retiree Only ☐ Retiree + Spouse/DP ☐ Retiree + Child ☐ Family

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4e. ADD NEW DEPENDENT (Skip If Not Adding Dependents to Plans)

DEPENDENT #1 ☐

LAST NAME _____ FIRST NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Child ☐ Spouse ☐ Domestic Partner (DP)

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____
MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

DEPENDENT #2 ☐

LAST NAME _____ FIRST NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____
MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

DEPENDENT #3 ☐

LAST NAME _____ FIRST NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

Gender: ☐ Male ☐ Female

Benefits: ☐ Medical ☐ Dental ☐ Vision

Relationship: ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____
MEDICARE # PART A EFFECTIVE DATE PART B EFFECTIVE DATE

4f. SICK LEAVE CHANGES:

NUMBER OF HOURS TO USE MONTHLY: _____

5. RETIREE WHO CHANGED MEDICAL PLANS ARBITRATION AGREEMENTS AND REQUIRED SIGNATURES

KAISER HEALTH PLAN MEMBERS

SIGNATURE REQUIRED FOR NEW KAISER PERMANENTE HEALTH CARE PLAN MEMBERS

Kaiser Foundation Health Plan Arbitration Agreement: PID 7056, 605191, 60192, 605193 EU 9, 7009

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

_____
SIGNATURE OF RETIREE DATE

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6. INDIVIDUALS WITH MEDICARE WHO CHANGED MEDICAL PLAN REQUIRED ACKNOWLEDGEMENT, INFORMATION AND SIGNATURES

By completing this enrollment application, I agree to the following:

Aetna/Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Aetna/Kaiser Permanente serves a specific service area. If I move out of the area that Aetna/Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Aetna/Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook or Evidence of Coverage document from Aetna/Kaiser Permanente when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Aetna/Kaiser Permanente coverage begins, I must get all of my health care from Aetna/Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Aetna/Kaiser Permanente and other services contained in my Aetna/Kaiser Permanente Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Aetna/Kaiser Permanente WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna/Kaiser Permanente, he/she may be paid based on my enrollment in Aetna/Kaiser Permanente .

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna/Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Option to request materials in language other than English (language preference) or in accessible formats.

Aetna: If you need information in another language or accessible format (e.g. large print or braille), contact Aetna at 1-888-267-2637 (TTY: 711) 8 AM to 6 PM, local time, Monday through Friday.

Kaiser Permanente: Please contact Kaiser Permanente at 1-800-443-0815 if you need information in an accessible format or language other than English. Office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711.

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MEDICARE MEMBER – REQUIRED IF RETIREE AND/OR DEPENDENT ARE ENROLLED IN MEDICARE

RETIREE (IF APPLICABLE)

Will you have other prescription drug coverage in addition to Aetna/Kaiser Permanente? ☐ YES ☐ NO

If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE | **ID NUMBER FOR OTHER COVERAGE**

EMPLOYER OR UNION NAME | **GROUP NUMBER**

NAME AND SIGNATURE (REQUIRED REGARDLESS OF ANSWER TO 1ST QUESTION) | **DATE**

DEPENDENT (IF APPLICABLE)

Will you have other prescription drug coverage in addition to Aetna/Kaiser Permanente? ☐ YES ☐ NO

If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE | **ID NUMBER FOR OTHER COVERAGE**

EMPLOYER OR UNION NAME | **GROUP NUMBER**

NAME AND SIGNATURE (REQUIRED REGARDLESS OF ANSWER TO 1ST QUESTION) | **DATE**

COMMENTS OR SPECIAL INSTRUCTIONS

FINAL SIGNATURE

7. REQUIRED! ALL RETIREES MUST ACKNOWLEDGE & SIGN

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

☐ **I have read, understand, and agree to the terms and conditions above.**

DATE | **SIGNATURE OF RETIREE**

QUESTIONS?

Visit our website for detailed plan information and rates!

https://www.smcgov.org/hr/oe-retirees

FOR HR USE ONLY:

Date Entered in BCC: _____ Date OE Change Confirmation sent: _____ HR Partner: _____