



RETIREE OPEN ENROLLMENT CHANGE FORM

PLEASE SUBMIT THIS FORM ONLY IF MAKING CHANGES

E-Mail: benefits@smcgov.org | Fax: 650-670-3080

- **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 6, 2026.**
- 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, 2027**

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
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☐ CHECK BOX IF ADDRESS HAS CHANGED

Note: Using this form to change your address with HR-Benefits for your County health benefits does not change it with SamCERA. To change your address for retirement/pension benefit, please contact SamCERA at (650)599-1234 or samcera@samcera.org

Permanent Address	STREET ADDRESS	NO P.O. BOXES
	CITY	STATE

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. 2026.

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. 2026.

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 medical 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 (\$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	UHC 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	<hr/> LAST NAME FIRST NAME <hr/>		Gender: ☐ Male ☐ Female
	<hr/> SOCIAL SECURITY # DATE OF BIRTH <hr/>		Benefits: ☐ Medical ☐ Dental ☐ Vision
	COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____		Relationship: ☐ Child ☐ Spouse ☐ Domestic Partner (DP)
	MEDICARE # _____		PART A EFFECTIVE DATE _____ PART B EFFECTIVE DATE _____
☐ DEPENDENT #2	<hr/> LAST NAME FIRST NAME <hr/>		Gender: ☐ Male ☐ Female
	<hr/> SOCIAL SECURITY # DATE OF BIRTH <hr/>		Benefits: ☐ Medical ☐ Dental ☐ Vision
	COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____		Relationship: ☐ Child
	MEDICARE # _____		PART A EFFECTIVE DATE _____ PART B EFFECTIVE DATE _____
☐ DEPENDENT #3	<hr/> LAST NAME FIRST NAME <hr/>		Gender: ☐ Male ☐ Female
	<hr/> SOCIAL SECURITY # DATE OF BIRTH <hr/>		Benefits: ☐ Medical ☐ Dental ☐ Vision
	COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: _____		Relationship: ☐ Child
	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

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:

UnitedHealthcare/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.

UnitedHealthcare/Kaiser Permanente serves a specific service area. If I move out of the area that UnitedHealthcare/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 UnitedHealthcare/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 UnitedHealthcare/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 UnitedHealthcare/Kaiser Permanente coverage begins, I must get all of my health care from UnitedHealthcare/Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by UnitedHealthcare/Kaiser Permanente and other services contained in my UnitedHealthcare/Kaiser Permanente Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR UnitedHealthcare/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 UnitedHealthcare/Kaiser Permanente, he/she may be paid based on my enrollment in UnitedHealthcare/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 UnitedHealthcare/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.

UnitedHealthcare: If you need information in another language or accessible format (e.g. large print or braille), contact UnitedHealthcare at 1-877-842-3210 (TTY: 711) 7 AM to 8 PM, ET, 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 UnitedHealthcare / Kaiser Permanente? If yes, please list your other coverage and identification (ID) number(s) for that coverage.	☐ YES	☐ NO
	NAME OF OTHER COVERAGE	ID NUMBER FOR OTHER COVERAGE	
	EMPLOYER OR UNION NAME	GROUP NUMBER	
	NAME AND SIGNATURE (REQUIRED REGARDLESS OF ANSWER TO 1 ST QUESTION)	DATE	
DEPENDENT (IF APPLICABLE)	Will you have other prescription drug coverage in addition to UnitedHealthcare / Kaiser Permanente? If yes, please list your other coverage and identification (ID) number(s) for that coverage.	☐ YES	☐ NO
	NAME OF OTHER COVERAGE	ID NUMBER FOR OTHER COVERAGE	
	EMPLOYER OR UNION NAME	GROUP NUMBER	
	NAME AND SIGNATURE (REQUIRED REGARDLESS OF ANSWER TO 1 ST QUESTION)	DATE	

COMMENTS OR SPECIAL INSTRUCTIONS

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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 mailed: _____ HR Partner: _____