Medical / Dental Plan Enrollment & Change Form

LAPRA

For office use only

Effective Date:	Group Number:	Fund Code:	Part Code:

SECTION 1 ACTION REQUESTED

☒ OPEN ENROLLMENT

RESET ALL FORM FIELDS

SECTION 2 MEDICAL & DENTAL PLAN ELECTION

MEDICAL ☐ Kaiser HMO ☐ Anthem Blue Cross PPO (Prudent Buyer) ☐ Anthem Blue Cross HMO (CaliforniaCare)
Coverage Category ☐ Single ☐ 2-Party ☐ Family *(Indicate Medical Group/IPA No. below)*

DENTAL ☐ Anthem Blue Cross PPO ☐ Anthem Blue Cross HMO *(Indicate Dental Group/IPA No. below)*
Coverage Category ☐ Single ☐ 2-Party ☐ Family

SECTION 3 YOUR INFORMATION

Last Name	First Name, MI	Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Social Security Number
Birth Date	Email Address	***Medical HMO Enrollee:*** IPA/PCP Code	***Dental HMO Enrollee:*** Dentist Code

Street Address	Unit #	City	State	Zip Code	Phone Number

SECTION 4 DEPENDENT INFORMATION *Social Security Numbers are required under CMS Regulations and by the IRS*

Sex	Last Name	First Name, MI	Birth Date	Social Security Number	Coverage Enrolled	If age 26 or older, IRS qualified dependent	HMO Enrollees Only: IPA/PCP Code	Dentist Code
☐ M ☐ F	Spouse/Domestic Partner				☐ Med ☐ Dent	N/A	Medical Code	Dental Code
☐ M ☐ F	Child				☐ Med ☐ Dent	☐ No ☐ Yes	Medical Code	Dental Code
☐ M ☐ F	Child				☐ Med ☐ Dent	☐ No ☐ Yes	Medical Code	Dental Code
☐ M ☐ F	Child				☐ Med ☐ Dent	☐ No ☐ Yes	Medical Code	Dental Code
☐ M ☐ F	Child				☐ Med ☐ Dent	☐ No ☐ Yes	Medical Code	Dental Code

To be eligible as a Domestic Partner, the Member and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State, the City of Los Angeles or the Los Angeles Fire & Police Pensions. If you are adding more than 4 children, please complete another form.

SECTION 5 OTHER COVERAGE FOR ALL ENROLLING MEMBERS AND DEPENDENTS – All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person: _____ Insurance Company_____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, names of persons: _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance Company:_____ Date Coverage Began: _____ Date Ended: _____

C. Does any person applying for coverage currently have **dental** insurance coverage? ☐ Yes ☐ No
If yes, names of persons: _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance Company:_____ Date Coverage Began: _____ Date Ended: _____

D. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SECTION 6 MEDICARE SECTION – Complete if you, your spouse or dependent child(ren) have Medicare coverage.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

CONTINUED ON NEXT PAGE

SECTION 7 PLEASE READ CAREFULLY – Signature required

I attest by signing this form 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.

I acknowledge that if any one of the dependents that I have listed on this form, or any dependents I enroll in the future, do not meet or no longer meet the eligibility requirements as described in LAPRA's Eligibility Booklet, I will be financially and legally responsible for the cost of medical, dental and vision services provided to my ineligible dependent during the period of ineligibility and that I may be financially and legally responsible for the cost of any subsidy paid to LAPRA, on your behalf, by either the City of Los Angeles or the Los Angeles Firemen and Police Pension Department. I understand that if I do not notify LAPRA within 31 days from the date my covered dependent becomes ineligible, the ineligible dependent's coverage will be terminated retroactively to the first of the month following the date the dependent becomes ineligible.

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until LAPRA's next open enrollment. If I am declining coverage for myself, my spouse, my domestic partner or my dependents because of other group health insurance coverage, I must tell LAPRA. I understand that I may enroll myself or my dependents in this plan provided I request enrollment with 31 days after my other group health insurance coverage ends. I may also enroll following marriage (with my spouse), registration (with my domestic partner), childbirth or adoption (with my spouse and that child only) provided I request enrollment within 31 days after the marriage, registration, birth or adoption.

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.

COBRA/CAL-COBRA CONTINUATION: You may continue your health care coverage by 1) completing the remained 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 LAPRA, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation 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 the Los Angeles Police Relief Association, Inc. discontinues coverage with Anthem Blue Cross, or Kaiser Permanente
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 State 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 premiums 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: As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

Kaiser Foundation Health Plan Arbitration Agreement

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 Required for Kaiser Permanente Plan **Date**

ANTHEM BLUE CROSS REQUIREMENT FOR BINDING ARBITRATION - IF YOU ARE APPLYING COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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 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. 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 a medical malpractice, that is as to whether any medical services rendered under this contact were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as 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 contact, 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 ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPAITON IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVIERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

SIGNATURE	**DATE**