County of Sacramento, Employee Benefits Office
700 H Street, Room 4667, Sacramento, CA 95814

916.874.2020 **PHONE** 916.874.4621 **FAX** MyBenefits@Saccounty.gov **EMAIL**
http://www.personnel.saccounty.net/Benefits/Pages/default.aspx **WEBSITE**

DISTRICT Name: SETA

Reason for Change:

SPECIAL DISTRICT ENROLLMENT FORM due within 30 days, please return to your District Human Services Department

EMPLOYEE INFORMATION

Last Name	First Name	M.I.	Birthdate	SSN
Physical Address	City	Zip	Phone	Email
Dr. Name	Provider ID #		Existing patient? ☐Y ☐N	

Step1 – Choose a plan and coverage level:

MEDICAL COVERAGE			DENTAL COVERAGE	OPTIONAL VISION		HEALTH SAVINGS ACCOUNT
☐SINGLE ☐FAMILY ☐WAIVE	☐ KAISER PERMANENTE ☐ SUTTER HEALTH PLUS ☐ WESTERN HEALTH ADVANTAGE	☐HMO ☐HIGH DEDUCTIBLE	☐SINGLE ☐FAMILY ☐WAIVE	☐SINGLE ☐FAMILY ☐WAIVE	☐Basic ☐Enhanced	HSA-$_____(Annual) ☐ ENROLL ☐ CHANGE ☐WAIVE Under age 55 Single-$4,300 Family-$8,550 Over age 55 Single-$5,300 Family-$9,550

Step 2 – Choose Life Insurance Coverage:

Basic Life Plan	☐ $15K			☐ $18K			☐ $50K		
Optional Life - Employee	☐ Option 1A	☐ Option 1	☐ Option 2	☐ Option 3	☐ Option 4	☐ Option 5	☐ Option 6	☐ Option 7	☐WAIVE
Employee Annual Salary	$								

Life – Spouse/DP	**Choose Basic and/or Optional Coverage. Optional amount in multiples of $10,000. Optional cannot exceed employee coverage.**	☐ Basic	☐ Option	Requested Amount: $
Life – Child 1	**Choose Basic and/or Optional Coverage.**	☐ Basic	☐ Option	$15,000
Life – Child 2	**Choose Basic and/or Optional Coverage.**	☐ Basic	☐ Option	$15,000
Life – Child 3	**Choose Basic and/or Optional Coverage.**	☐ Basic	☐ Option	$15,000

DEPENDENT ENROLLMENT

			Choose coverage for each family member
☐Spouse ☐Domestic Partner ☐M ☐F — Last Name First Name	SSN	Birthdate	☐Dental ☐Vision ☐Medical Dr. Name: Provider ID#: Existing patient? ☐Y ☐N
Child 1 ☐M ☐F	SSN	Birthdate	☐Dental ☐Vision ☐Medical Dr. Name: Provider ID#: Existing patient? ☐Y ☐N
Child 2 ☐M ☐F	SSN	Birthdate	☐Dental ☐Vision ☐Medical Dr. Name: Provider ID#: Existing patient? ☐Y ☐N
Child 3 ☐M ☐F	SSN	Birthdate	☐Dental ☐Vision ☐Medical Dr. Name: Provider ID#: Existing patient? ☐Y ☐N
Indicate if any child over age 26 is disabled ☐Y ☐N	If yes, which child?		

Documentation is required for dependents to validate their legal relationship to you. Failure to provide documentation will result in the dependent not being enrolled.

SIGN AUTHORIZATION ON BACK →

INSTRUCTIONS: If you are waiving coverage, read and initial the Waiver of Coverage section, then read and sign and date at the bottom. For all other changes, read and initial the arbitration agreement next to your selected plan, then read and sign and date at the bottom "X".

****WAIVER OF COVERAGE**-I authorize the County of Sacramento to terminate my participation in the County sponsored medical and/or vision plans. I understand I may be required to show proof of enrollment in another group plan satisfactory to the County in accordance with my Labor Agreement. If approved, coverage shall end the last day of the month in which the request was made, or December 31st for Open Enrollment elections. **Initials: _____ (also sign at "X" below)**

BINDING ARBITRATION-**Health plan carriers handle and resolve member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes the Plans use binding arbitration as the final method for resolving all such disputes. As a condition of your membership in the Plan, you must initial next to your plan carrier to indicate that you understand and agree to the following:**

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. **KAISER -----Initials: _____ (also sign at "X" below)**

WESTERN HEALTH ADVANTAGE (WHA) and SUTTER HEALTH PLUS (SHP)

A. On behalf of myself and my eligible Dependents, I hereby apply for health care coverage offered through my Employer, and agree to be bound by the Group Service Agreement and Evidence of Coverage and Disclosure Form for the plan selected, and this Enrollment/Change Form.

B. Arbitration agreement: I agree and understand that any and all disputes between myself (including any heirs or assigns) and the Plan, 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 arbitration 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.

WESTERN HEALTH ADVANTAGE-- Initials: _____ (also sign at "X" below) SUTTER HEALTH PLUS-- Initials: _____ (also sign at "X" below)

Kaiser and Sutter Health Savings Account Certification:

By signing below, I appoint County of Sacramento, as the agent for the purpose of opening and administering a health savings account (HSA) on my behalf. I also acknowledge and certify that: I wish to establish a health savings account (HSA) with Optum Bank® as custodian. I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I understand and agree that my HSA will be opened and governed by Optum Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with Optum Bank's Truth in Savings New Account Disclosure, Privacy Notice and Schedule of Fees. I authorize Optum Bank to provide information about my HSA, including my account number, to my employer and those acting on behalf of my employer or Optum Bank, in connection with the establishment and maintenance of my HSA. I acknowledge that my employer and all others acting on behalf of my employer, may provide information on my behalf to establish and maintain my HSA and authorize my employer and its designee to take such action deemed necessary and appropriate by my employer to administer my HSA, including, but not limited to, making deposits and correcting errors where necessary. I understand my monthly account statements and all other HSA disclosures and documentation will be made available to me electronically. I agree to notify Optum Bank if I wish to have statements mailed to my home address. I understand that I have requested an Optum Bank debit MasterCard® card.I certify that the information provided in this application is true and complete. I certify that I have received or viewed the Bank's statement of the hardware and software requirements for access to and retention of electronic records and that I have demonstrated the ability to access the Bank's website where electronic statements and other documentation are stored. I instruct the Bank, unless otherwise notified and instructed by me, to provide the Custodial and Deposit Agreement and all other HSA notices, disclosures and information related to and governing my HSA to me online at optumbank.com. I agree that Employer will remain my agent unless and until Employer and the Bank receive notice that the appointment of Employer as my agent has been terminated, that I am no longer employed by Employer, or that I am no longer an HSA eligible individual; or I receive a notice from the Bank that my application for an HSA has been declined.

KAISER (Optum Bank) -- Initials: _____ (also sign at "X" below) **SUTTER HEALTH PLUS (Optum Bank) -- Initials: _____ (also sign at "X" below)**

WHA Health Savings Account:

I hereby certify that I meet the Eligibility Requirements outlined above. I understand that, in compliance with the USA Patriot Act, HealthEquity must verify the identity of all customers seeking to open an HSA, and that I may be contacted to provide additional information and/or documentation if this is required to comply with the Act. I understand that, with this signed authorization, a HealthEquity HSA will be opened for me as part of my enrollment with WHA. I authorize WHA to disclose my claims data to HealthEquity after my HSA is established in order to make that information available to me for reconciliation with my HSA.

WHA (Health Equity) -- Initials: _____ (also sign at "X" below)

AUTHORIZATION-All information on this form is true and correct; I understand it is the basis on which coverage may be issued under the plan(s). Any dependents listed are my lawful spouse/domestic partner/and children, and are eligible for enrollment as my dependents. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. My signature indicates my acceptance of the terms and conditions of the evidence of coverage for the carrier I have selected including arbitration, benefit coverage, and all associated policies.

X EMPLOYEE SIGNATURE: _____ Date_____

Office Use Only	Effective Date: 1/1/2025	Benefits Staff Reviewed:	Entered Benefitbridge (circle one) Y/N	Date: