



BENEFIT ENROLLMENT AND CHANGE FORM

Group Plan	Group Number	Effective Date:
Kaiser Permanente- HMO	102249	
PacifiCare- HMO	524520	
PacifiCare- PPO	00014614	
Guardian	371593	
Lincoln Financial- Life	10054011	
Lincoln Financial- LTD	10054012	

SECTION A. PURPOSE OF APPLICATION

New Employee
 Rehire
 Part-time to Full-time
 Open Enrollment
 *Add Coverage
 *Delete Coverage
 Name Change
 Address Change
 *Reason of Change / Qualifying Event: _____

SECTION B. BASIC EMPLOYEE INFORMATION (PLEASE PRINT)

Last name	First	M.I.	Social Security #	Date of Birth	Date of Hire / Rehire
Home Address			Home phone #	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Annual Salary \$,
City, State, Zip				Email	
Number of hours worked weekly: _____ <i>(minimum 32 hours /week required)</i>			Work phone #	Job Title	
Life Insurance Beneficiary Designations <i>(name / relationship / %)</i>			Life/A&D: <input checked="" type="checkbox"/> Employee	Disability: <input type="checkbox"/> LTD (12 month wait)	Pre-tax Premiums <input checked="" type="checkbox"/> Participant

SECTION C. BENEFIT ELECTIONS FOR YOURSELF AND YOUR DEPENDENTS

Full Name PLEASE PRINT CLEARLY	Date of Birth mo / day / year	Gender	Medical Selection	Dental Selection	Vision Selection
	Social Security # ### - ## - ####		PacifiCare: <input type="checkbox"/> HMO <input type="checkbox"/> PPO Kaiser Permanente: <input type="checkbox"/> HMO Plan PCP# required if electing HMO	<input type="checkbox"/> DHMO <input type="checkbox"/> DPPO Dental office# required if electing DHMO	Please make a selection
Employee	Noted Above	<input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive
	Noted Above	<input type="checkbox"/> M	PCP/IPA# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Office # _____	
<input type="checkbox"/> Spouse/ <input type="checkbox"/> Domestic Partner	/ /	<input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive
Date of Marriage: _____	- -	<input type="checkbox"/> M	PCP/IPA# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Office # _____	
Child(1) † Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive
	- -	<input type="checkbox"/> M	PCP/IPA# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Office # _____	
Child(2) † Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive
	- -	<input type="checkbox"/> M	PCP/IPA# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Office # _____	
Child(3) † Full-time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Waive
	- -	<input type="checkbox"/> M	PCP/IPA# _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Office # _____	

SECTION D. ENROLLING DEPENDENT CHILDREN?

If you have listed dependent child(ren), please answer the questions below about your dependent(s):

Yes No Developmentally/physically disabled? Name(s) _____ Disability _____
 Yes No Different Address for Dependents? Name(s) _____ Address/phone# _____
 Yes No Are any dependent children adopted? If "yes" indicate name and date of placement: _____
 Yes No Have you included stepchildren? If "yes" indicate name(s) _____
 Yes No Are they dependent on you for support and maintenance? _____

EMPLOYEE PACIFICARE AUTHORIZATION:

I acknowledge that I have received and read the enrollment materials for each of the benefit plan options indicated in this benefit enrollment form. I further acknowledge that the information provided by me in this benefit enrollment form is true and correct to the best of my knowledge.

I understand that any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. This certifies that I have read and understand the above notice.

Authorization to Deduct Contributions: I authorize deductions from my earnings of the required contributions, if any, toward the cost of coverage.

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to 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.

Signature of Employee Required for Kaiser Permanente HMO Plan:	Date:	Initials of Employer:
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EMPLOYEE GUARDIAN AUTHORIZATION:

I hereby apply for the group benefit(s) indicated above. I understand I must be actively at work or my life coverage will not take effect until I have completed a waiting period (as defined in the group plan) of full time service. This requirement does not apply to eligible retirees. I understand that life insurance coverage for my dependents will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex. I authorize my employer to take deductions from my pay or agree that the contributions be added to my dues; if they are required for the insurance. The information provided above is true and correct to the best of my knowledge. Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

DHMO Dental: MDC CA Late entrant penalties or proof of insurability do not apply to Pre Paid dental coverage. The pre paid Dental plan refers to, as applicable, Managed DentalGuard dental HMO plans underwritten by Managed Dental Care. Eligibility for this coverage is only available at the open enrollment period.

PPO Dental: If you waive dental coverage and later decide to enroll, you may be subject to late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late entrant penalties if you lose coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

PRE-TAX OR PREMIUMS (POP):

Generally, you make an irrevocable election for the entire Plan Year and you may not change it during the Plan Year. You may always change your pre-tax elections in coordination with each new Plan Year. Except as outlined below, you may not change your election in any of the following ways during the Plan Year:

- Your participation in this Plan,
- Your salary reduction amounts, or
- Your election of specific coverages under the Employee Benefit Plan

There are some specific exceptions to the irrevocability rule regarding when you can change your election mid-year. Generally, you must experience a Status Change or other event that qualifies for a Mid-Year change of election.

IMPORTANT INFORMATION YOU SHOULD KNOW:

- *Medical, Dental & Vision: I understand that if I waive or elect coverage at a later date, late entrant penalties, such as service waiting periods or enrollment delays may apply.*
- *Qualifying Event: If you do not enroll in these programs or make the necessary changes at this time, you may not be able to do so until your annual re-enrollment period (as defined in the group Plan). Mid-year enrollments are granted only for Qualifying events: marriage, newborns, adoption, death, divorce/legal separation, loss of coverage, etc.*

Signature of Employee:	Date:	Initials of Employer:	Date:
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I have read & understood the provisions set out above on this form. All information on this form is correct & true. I understand that it's the basis on which coverage may be issued under the plan. Any misstatements/omissions may result in future claims being denied and/or my coverage being rescinded.