



## RETIREE/SURVIVOR

## 2009 ENROLLMENT/CHANGE FORM

### 1. Personal Information

Name (Last, First, MI)	Social Security Number	E-mail Address	Emergency Contact (a family member, friend, or legal advisor who DOES NOT live at your address) Name:  Phone number:
Street Address	Birth Date	Home Phone	
City/State/Zip	<i>Check one:</i> <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor	<i>Check one:</i> <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	Employee Number

### 2. Reason for Completing This Form

<input type="checkbox"/> New enrollment <input type="checkbox"/> Name/address change <input type="checkbox"/> Change in dependent coverage  ↓ Indicate a reason in the next column if you are adding or removing a dependent from your coverage.	<b>Change in Status</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Legal Separation <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Child past eligible age <input type="checkbox"/> Death of dependent <input type="checkbox"/> Spouse gained or lost coverage <input type="checkbox"/> Other	<b>Date of Change of Status</b> _____ _____ _____ _____ _____ _____ _____
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### 3. Medical Coverage

<b>Indicate your choice below:</b> <input type="checkbox"/> Blue Shield PPO Plan <input type="checkbox"/> Blue Shield HMO Plan – <i>Complete Part 6-B on back side</i> <input type="checkbox"/> Kaiser Permanente HMO	<b>Indicate coverage level:</b> <input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family
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### 4. Dental Coverage

<b>Indicate your choice below:</b> <input type="checkbox"/> Delta Dental PPO <input type="checkbox"/> SafeGuard Dental (HMO) – <i>Complete Part 6-B on back side</i>	<b>Indicate coverage level:</b> <input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family
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### 5. Vision Coverage

Vision Service Plan	<b>Indicate coverage level:</b> <input type="checkbox"/> Me only <input type="checkbox"/> Me + spouse/domestic partner <input type="checkbox"/> Me + child(ren) <input type="checkbox"/> Me + family
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### 6. Enrollment Information

If you are adding or removing dependents or changing address information at any time other than annual enrollment, you must submit this form within 31 days of a family status change (marriage, divorce, birth, etc.).

#### PART 6-A – Enrollee Information

Please complete the following section for each person you are enrolling, including yourself. If you are enrolling more than three children, please list their names and information on a separate page. Sign, date, and attach that page to this form.

	Add	Delete	Name (Last, First, MI)	Sex	Birth Date	Social Security #
Self	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				
Child	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision				



**To complete your enrollment, you must read the arbitration information below and sign at the bottom.**

**Safeguard Provisions**

Each and every disagreement, dispute or controversy which remains unresolved concerning the construction, interpretation, performance or breach of this contract, or the provision of dental services under this contract after exhausting SafeGuard's complaint procedures, arising between the organization, a member or the heir-at-law or personal representative of such person, as the case may be, and SafeGuard, its employees, officers or directors, or participating dentist or their dental groups, partners, agents, or employees, may be voluntarily submitted to arbitration in accordance with the American Arbitration Association rules and regulations, whether such dispute involves a claim in tort, contract or otherwise. This includes, without limitation, all disputes as to professional liability or malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. It also includes, without limitation, any act or omission which occurs during the term of this contract but which gives rise to a claim after the termination of this contract. Arbitration shall be initiated by written notice to the President, SafeGuard Health Plans, Inc., P.O. Box 30900, Laguna Hills, California 92654-0900. The notice shall include a detailed description of the matter to be arbitrated.

**Kaiser Permanente Provisions**

**Kaiser Foundation Health Plan Arbitration Agreement:**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with 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.

**Please Sign Below**

X \_\_\_\_\_

Your Signature

\_\_\_\_\_ Date