HR USE ONLY: Cigna Med HMO Select HMO Full PPO VSP

No FSA / FSA (notified TPA: _____) Kaiser Permanente Cigna Dental DHMO/PPO

Print Form

SDSU Research Foundation
Benefits Enrollment / Change / Decline Form

Red ID: | | | | | | | | | |

Social Security Number: | | | | | | | | | |

Last Name: (as it appears on Social Security Card)	First Name:	Middle Initial:
Address:	City:	State:
Zip Code:	Home Phone:	Work Phone:
E-mail:	Hire Date:	Status Change Date:

1. Classification:

◯ Active (So. Cal) ◯ Active (No. Cal) ◯ Active (Outside of Cal)

2. Reason for Request (Please note in addition to Proof of Dependency, Proof of Status Change may be required)

◯ New hire
◯ Marriage
◯ Birth/adoption/legal guardianship of dependent
◯ Change in child(ren)'s, spouse's or domestic partner's health coverage
◯ Other Describe:

◯ Divorce/legal separation
◯ Dependent status change due to age
◯ Open enrollment
◯ End of employment

3. Select your Enrollment Coverage: (Check all that apply)

Select 1 Medical Plan			Select 1 Dental Plan			Select Vision
Kaiser Permanente HMO	Cigna HMO Select Network	Cigna HMO Full Network	Cigna PPO (OAP)	Cigna Dental (DHMO)	Cigna Dental (PPO)	VSP Vision
◯ Employee Only	◯ Employee Only	◯ Employee Only	◯ Employee Only	◯ Employee Only	◯ Employee Only	◯ Employee Only
◯ Employee + 1	◯ Employee + 1	◯ Employee + 1	◯ Employee + 1	◯ Employee + 1	◯ Employee + 1	◯ Employee + 1
◯ Employee Plus 2/ or more	◯ Employee Plus 2/ or more	◯ Employee Plus 2/ or more	◯ Employee Plus 2/ or more	◯ Employee Plus 2/or more	◯ Employee Plus 2/ or more	◯ Employee Plus 2/ or more
◯ Waive Coverage*	◯ Waive Coverage*	◯ Waive Coverage*	◯ Waive Coverage*	◯ Waive Coverage*	◯ Waive Coverage*	◯ Waive Coverage*

HR Use Only

Medical: Remains EO / E1 / E2 E _____ To E _____ Waive Coverage _____

Dental: Remains EO / E1 / E2 E _____ To E _____ Waive Coverage

Kaiser Permanente Group Number:	◯ Active (So. Cal) 104306-00	◯ Active (No. Cal) 603146-0		
Cigna Medical Group Number:	◯ HMO (active) 3341296-0001	◯ PPO (active) 3341296-0001	◯ HMO (Outside CA) _____	◯ PPO (Outside CA) _____
Cigna Dental Group Number:	◯ Active DHMO 3341296-0002	◯ Active PPO 3341296-0002	◯ Active DMO/PPO (Outside CA) _____	

Effective Date: _____ Checked: _____/ Audited: _____ Keyed: _____/ Audited: _____

4. Only list the individuals you are adding / dropping to the medical or dental insurance plans:

A. Employee (If not adding or if you are dropping yourself complete Section 5)

Last Name:	First Name:	Middle Initial:
Birth Date: (month/day/year)	**Kaiser Permanente:** Previous Medical Record Number:	

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship: ◯ Self

Cigna (HMO):
PCP # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna Dental DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

B. Spouse / Domestic Partner (If not adding or if you are dropping eligible spouse complete Section 5)

Last Name:	First Name:	Middle Initial:
Social Security Number:	**Kaiser Permanente:** Previous Medical Record Number:	
Birth Date: (month/day/year)		

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship ◯ Spouse ◯ Domestic Partner

Cigna (HMO):
PCP # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna Dental DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

C. Dependent (If not adding or if you are dropping eligible dependents complete Section 5)

Last Name:	First Name:	Middle Initial:
Social Security Number:	**Kaiser Permanente:** Previous Medical Record Number:	
Birth Date: (month/day/year)		

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship ◯ Child ◯ Disabled

Cigna (HMO):
PCP # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

D. Dependent (If not adding or if you are dropping eligible dependents complete Section 5)

Last Name: | First Name: | Middle Initial:

Social Security Number:

Birth Date: (month/day/year)

Kaiser Permanente:
Previous Medical Record Number:

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship ◯ Child ◯ Disabled

Cigna (HMO):
PCP # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

E. Dependent (If not adding or if you are dropping eligible dependents complete Section 5)

Last Name: | First Name: | Middle Initial:

Social Security Number:

Birth Date: (month/day/year)

Kaiser Permanente:
Previous Medical Record Number:

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship ◯ Child ◯ Disabled

Cigna (HMO):
PCP # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

F. Dependent (If not adding or if you are dropping eligible dependents complete Section 5)

Last Name: | First Name: | Middle Initial:

Social Security Number:

Birth Date: (month/day/year)

Kaiser Permanente:
Previous Medical Record Number:

Gender: ◯ Male ◯ Female

Medical: ◯ Adding ◯ Dropping

Dental: ◯ Adding ◯ Dropping

Vision: ◯ Adding ◯ Dropping

Relationship ◯ Child ◯ Disabled

Cigna (HMO):
PCP office # (10 digits)
(Required if enrolling in Cigna HMO)

Current Patient ◯ Yes ◯ No

Physician Name & Group:

Cigna Dental DHMO:
DHMO Office # (6 digits) (Required **only** if enrolling in Cigna Dental DHMO)

Current Patient ◯ Yes ◯ No Dentist Name:

5. Employee Health and/or Dental Declination Statement

If you wish to decline coverage for yourself and your dependent(s) who are eligible to be enrolled in SDSU Research Foundation's group health plans, please read the Late Enrollment Warning on the last page of this form and then proceed to read, complete, and sign this form.

I am declining to enroll for coverage under SDSU Research Foundation's **health** benefit plans for:

- ☐ Myself
- ☐ Spouse or Domestic Partner
- ☐ Spouse or Domestic Partner and Child(ren)
- ☐ Child(ren) or Domestic Partner Child(ren) only

I am declining to enroll for coverage under SDSU Research Foundation's **dental** benefit plans for:

- ☐ Myself
- ☐ Spouse or Domestic Partner
- ☐ Spouse or Domestic Partner and Child(ren)
- ☐ Child(ren) or Domestic Partner Child(ren) only

In the table below, list name, date of birth and gender of the person(s) you are declining coverage for:

Name	Date of Birth	Gender

Reason for Declining Health and/or Dental Coverage

If you are declining coverage under the SDSU Research Foundation's group health plan because you and/or your eligible dependent(s) have coverage under another health benefit plan, please indicate whether the coverage is provided by a group plan, individual plan, or some other plan, and complete the information below.

- ☐ Coverage under another employer's health benefit plan
- ☐ Coverage under another group health benefit plan
- ☐ Coverage under an individual health benefit plan
- ☐ Other

Name of Other Employer or Group Providing Coverage:

Insurance Company Providing Insurance:

Group Policy #

I acknowledge that I have been given the opportunity to enroll myself, and if applicable, my eligible dependent(s) in affordable group insurance benefits that are available to me through SDSU Research Foundation's group health plans. I understand that the Affordable Care Act (ACA) requires me to have insurance coverage or I may face a penalty imposed by the Internal Revenue Service (IRS). After careful consideration, I have decided NOT to enroll in the benefit plan through SDSU Research Foundation. Additionally, I have read and understand the circumstances in which I may later enroll in the plan without being considered a "late enrollee." By waiving coverage I understand that I will not be able to add coverage for myself or my dependents unless I have a status change. I understand that I must notify Human Resources within 31 days of the date of the qualified status change in order to make a change in my elections.

_____ Date: _____

Signature if Waiving Coverage (Required)

6. Life Insurance & Long Term Disability Policy

1. Primary Beneficiary Name:		Date of Birth:
Social Security Number:	Relationship:	(%)
Address:		
2. Primary Beneficiary Name:		Date of Birth:
Social Security Number:	Relationship:	(%)
Address:		
3 .Contingent Beneficiary Name:		Date of Birth:
Social Security Number:	Relationship:	(%)
Address:		

7. Flexible Spending Accounts (Health FSA and Dependent Care FSA)

Health FSA ($2,850 annual maximum) (Out of pocket expenses for medical, dental and vision)		Dependent Care FSA ($5,000 annual max. or $2,500 if married filing separately) (Child care, elder care expenses)	
☐ **ENROLL**	☐ **DECLINE**	☐ **ENROLL**	☐ **DECLINE**
Annual Election Amount		Annual Election Amount	

HR Use Only

Per Pay Period Amount	Per Pay Period Amount
Number of Pay Periods	Number of Pay Periods
Effective Date	Effective Date
Date of First Deduction	Date of First Deduction

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.

Date: _____

Signature Required for Kaiser Permanente Plan

Cigna Medical or Dental Plans Arbitration Agreement

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.

CALIFORNIA RESIDENTS ONLY: Cigna Health and Life Insurance Company and Cigna Dental Health, Inc. and its subsidiaries use binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and Cigna Health and Life Insurance Company, Cigna Dental Health, Inc. and its subsidiaries (including any of their agents, successors- or predecessors-in-interest, employees, or providers).

I understand that I am enrolling in one or both of the Cigna medical and/or dental plans.

Date: _____

Signature Required for Enrollment in Cigna Plans

Payroll Authorization Agreement

I authorize that any applicable pre-tax deductions be made from my paycheck for any employee premium contribution as is required and this election will continue during the term of my employment unless I change to an ineligible status or revoke authorization through a written declination process in accordance with the terms of the SDSURF Plan Document(s). Due to the advantages of pre-tax contributions, I understand my election as a participant in any sponsored benefit program cannot be changed during the plan year, other than Open Enrollment, unless I have a change in the status of my family. These are defined by IRS regulations and limited to: death, divorce, birth or adoption of a child, marriage, declaration or termination of a domestic partnership, or change in spouse's or domestic partner's employment, and other reasons as allowed by law. In most cases, the mid-year family status change must be reported to HR within 31 days of the qualified family status change and be accompanied by the appropriate proof documentation.

I have read and understood the provisions set out on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being reduced.

_____ **Date:** _____

Employee Signature (Required)

Late Enrollment Warning For Qualified Family Status Changes

An eligible employee and their dependent(s) must be enrolled in one of the SDSU Research Foundation's health plans during the initial enrollment period, which is normally 31 days from the date the employee or dependent(s) is first eligible to be covered.

An eligible employee and/or their dependent(s) who requests enrollment after the initial enrollment period will be considered a "late enrollee" and subject to coverage limitations unless the person qualifies under one of the late enrollee exceptions.

Late enrollee exceptions:

SDSU Research Foundation employees eligible for group health benefits who decline coverage during their initial enrollment period because they have coverage under another health benefit plan and indicate this reason for declining coverage, will not be considered late enrollees if, while still eligible, they subsequently wish to enroll in one of the SDSU Research Foundation health plans. To be exempt from the late enrollee limitations, the request for enrollment must be received by SDSU Research Foundation's Human Resources Department within 31 days after termination of coverage under the other health plan and coverage under the other health benefit plan must have ended because of:

- end of employment or change of employment status (your own or the person through whom you or they were covered)
- termination of the other health benefit plan
- the employer stops paying a required contribution for the person's coverage
- death of the person through whom they were covered
- divorce or dissolution of domestic partnership

Additionally, an employee who wishes to enroll in a different SDSU Research Foundation group health plan will not be considered a late enrollee if they elect a different plan during Open Enrollment. And, a spouse or minor child who is enrolled within 31 days after issuance of a court order directing that coverage be provided for the person under a covered employee's health benefit plan will not be considered a late enrollee.