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Human Resources Benefits Division, 4080 Lemon Street, P.O. Box 1569, Riverside, CA 92502, (951) 955-4981

RIVCO 1HR putting people first

County of Riverside, Human Resources Department

2019 *Retiree* Benefit Election Form

For Retirees Eligible for County Health Plans

Name:	**Social Security #:**	**Employee ID/Retiree Rec. #:**	
Street Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Retirement Date:**	
Status Change Effective:	***Reason for Change:***	**Email Address:** ***(if available)***	
Department Name:	**Bargaining Unit:**	**Job Title:**	

If you are the surviving spouse of a County of Riverside employee/retiree, please provide the former employee's name here.
Name:

This form (5 pages) must be signed, and returned to the County of Riverside Human Resources Department within 60 days of your retirement date, or any qualifying event resulting in a change in family status. Failure to submit this paperwork timely, may result in denial of coverage/changes.

MEDICAL PLAN OPTIONS

Please indicate your coverage level and your medical plan election (check one medical plan) below.

☐ No Change ☐ Waive Medical ☐ Single Party Coverage ☐ Two-Party Coverage ☐ Family Coverage

Early Retirees (Non-Medicare Eligible):

- ☐ United Healthcare HMO Signature Value - Alliance Network
- ☐ Exclusive Care EPO
- ☐ United Healthcare PPO
- ☐ Kaiser Permanente HMO

Medicare Eligible Retirees and/or Dependents:

- ☐ United Healthcare Medicare Advantage Plan*
- ☐ Exclusive Care Select Medicare Supplement ****
- ☐ United Healthcare EPO Coordination of Benefits*
- ☐ Kaiser Senior Advantage HMO Original Plan **
- ☐ United Healthcare Medicare PPO COB***
- ☐ Kaiser Senior Advantage HMO Low Plan **
- ☐ United Healthcare Medicare Indemnity COB***
- ☐ SCAN Health Plan HMO ***
- ☐ Exclusive Care Select Medicare Coordination ****

Important Information for Medicare Plans

If you are enrolling in Kaiser Senior Advantage (HMO), SCAN Health Plan (HMO), United Healthcare Medicare Assigned Plan, United Healthcare EPO Coordination of Benefits, United Healthcare Medicare PPO COB or United Healthcare Medicare Indemnity COB, you must complete a separate enrollment application, and supply a copy of your Medicare card. For more information on plans for Medicare-eligible retirees, please call the Benefits Help Line at (951) 955-4981, Option #1.

*You must be enrolled in both Medicare Part A and Part B to participate in these plans.

** If you or your dependents are OVER age 65 and you are NOT eligible for Medicare, please contact the Benefits Information Line for assistance at (951) 955-4981, Option #1. You will pay a higher monthly premium if you do not have Medicare Part A and Part B.

***You and all of your dependents must be enrolled in both Medicare Part A and Part B to participate in these plans.

**** Participants who are under age 65 and not eligible for Medicare, will be enrolled in the Exclusive Care EPO Plan. Participants must live within the plan's service area.

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Medicare Enrollment Information

If you or your dependents are Medicare eligible, please complete this section.

Name:	Medicare ID #:	Medicare Parts A and B Effective Dates: Part A: Part B:
Name:	Medicare ID #:	Medicare Parts A and B Effective Dates: Part A: Part B:

DENTAL PLAN OPTIONS

Please indicate your coverage level and dental plan election below.

☐ No Change ☐ Waive Dental ☐ Single Party Coverage ☐ Two-Party Coverage ☐ Family Coverage

☐ DeltaCare USA High-Option DHMO (10A)

Name and Address of Provider

☐ Local Advantage Blythe DHMO

☐ Local Advantage Plus DHMO

☐ Delta Dental PPO

VISION PLAN OPTIONS

Please indicate your coverage level and vision plan election below. To avoid duplicate coverage, check with your medical plan to see if vision services are covered.

☐ No Change ☐ Waive Vision ☐ Single Party Coverage ☐ Two-Party Coverage ☐ Family Coverage

☐ Medical Eye Services (MES) Vision Plan

RETIREE/DEPENDENT INFORMATION

Enter yourself and any eligible dependents you are enrolling onto your medical, dental, and/or vision plan below. Please indicate those dependents that are Medicare eligible.

Please indicate provider name or provider ID number. A provider selection is required for Exclusive Care (EPO), Scan Health Plan (HMO), United Healthcare HMO-Alliance Network, United Healthcare Medicare Assigned Plan, United Healthcare Medicare EPO Coordination of Benefits, DeltaCare USA High-Option DHMO (10A), Local Advantage Plus DHMO, Local Advantage Blythe DHMO. Provider ID numbers are listed in the carrier's provider directory, the carrier's website or can be obtained by calling the health, dental, or vision plan you selected. If you do not select a provider, one will be automatically assigned to you by the carrier.

RETIREE

Relationship	Employee Name:	Date of Birth:	☐ Male ☐ Female	Social Security #
SELF				

Medicare?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 1

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Medicare?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 2

Relationship:	Dependent Name:	Date of Birth:	☐ Male ☐ Female	Social Security #

Medicare?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

RELEASE OF INFORMATION: I authorize any physician, health care practitioner, hospital or other health care facility, clinic, health care service plan, or any other person or entity to release to any health care plan provider of the County of Riverside, a health care service plan, a self-insurer, or any insurance company, or its designee, all medical or personal information related to myself or any covered dependent, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: diagnosis or treatment; payment of health services rendered; billing, claims management, medical data processing, or other administrative function of the health plan in which I am enrolled through the County; peer review, including reviewing the competence or qualifications of health care professionals; utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; handling of member grievances or appeals, external independent review, or other health dispute resolution; coordination of care with providers of health care or other health care service plans; administering the health benefit plan; chronic disease management programs, to monitor or administer care of a covered benefit; and other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my health plan provider through the County of Riverside.

BINDING ARBITRATION: I understand that the health plans sponsored by the County of Riverside use neutral binding arbitration to resolve disputes between Members, including but not limited to, claims of 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 claims subject to ERISA, between myself and the health plan. 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 proceeding. The health plan and myself (and/or any enrolled dependents member), the parties to this 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. For additional information about each plan's arbitration provision, I may refer to the Disclosure and Evidence of Coverage, copies of which are available from each health plan.

AUTHORIZATION TO DEDUCT INSURANCE PREMIUM FROM RETIREMENT ALLOWANCE: I hereby apply for membership in the plan for myself and for any eligible dependents listed and authorize the Public Employees' Retirement System to deduct from my retirement allowance in accordance with rules of said system, premiums for the plan(s) in the amount certified to said system by the County of Riverside. I further authorize the County to certify to the Public Employees' Retirement System the amount of premiums to be deducted and any subsequent change in said amount. This deduction will continue until I file in the office of the County of Riverside Human Resources Department, Employee Benefits Division, a written request for termination and my premiums have been paid in full. I will notify the County of Riverside Human Resources Department, Employee Benefits Division of any qualifying event resulting in a change in family status.

DIRECT PAY: I understand that I will be placed on a direct pay plan if premiums cannot be collected in full from my retiree warrant (e.g. retiree warrant is insufficient to cover the full cost of the retiree premium). I hereby apply for membership in the plan for myself and for any eligible dependents listed. I will pay my premiums directly to the County of Riverside Human Resources Department. I understand that my premium payments must be received by the County of Riverside no later than the 25th of each month for the premium due the following month, and that coverage for myself and my enrolled dependents may be terminated if premiums are late.

Changes in Coverage: If you or your dependents experience a qualifying event resulting in a change in family status, you must contact Human Resources to request an enrollment change within 60 days from the date of the qualifying event. If you do not request enrollment within 60 days, you must wait until the next County Annual Enrollment period before you will be permitted to make a change.

Health Insurance Portability and Accountability – Special Enrollment Rights: If you are waiving enrollment for yourself and your dependents (including your spouse/domestic partner) because of other health insurance coverage, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents, provided that you request enrollment within 60 days after the qualifying event occurs.

CONTINUED ON NEXT PAGE / SIGNATURE REQUIRED

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Authorization, Release, and Signature:

I understand that I must meet the eligibility requirements of my elections as indicated on this Benefit Election Form. Submission of this Benefit Election Form is not confirmation that eligibility requirements have been met or verified.

I have read, understand and agree to the terms and conditions set forth on this Benefit Election Form, including the Release of Information, Binding Arbitration, Changes in Coverage and Medical Waiver, if applicable.

I certify that I have read, understand, and agree to the terms outlined on this Benefit Election Form.

This form must be signed and returned to the County of Riverside Human Resources Department within 60 days of your retirement date, or any qualifying event resulting in a change in family status. Prior to submitting this form, please make a copy for your records.

Submit to: **County of Riverside**
Human Resources Department - Benefits Division
P.O. Box 1569
Riverside, CA 92502-1569
Fax: (951) 955-3490
Benefits Information Line: (951) 955-4981, Option 1

Signature *(required)* Date *(required)*

CONTINUED ON NEXT PAGE / SIGNATURE REQUIRED

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Complete this section only if you wish to give the County of Riverside Benefits Division authorization to discuss your eligibility and enrollment with persons to whom you designate (e.g., spouse, child, caregiver, etc).

I, _____ hereby authorize the use or disclosure of my health information as described in this authorization.

1). Specific person/organization (or class of persons) authorized to release the information:
The County of Riverside Human Resources Benefits Division

2). Specific person/organization (or class of persons) authorized to receive and use the information:

_____

(Enter the person(s) to whom you authorize the County of Riverside to speak with regarding your eligibility, enrollment or payment of premiums.)

3). Specific and meaningful description of the information:
All Information necessary to administer my eligibility and enrollment in health plans sponsored by the County of Riverside.

4). Purpose of the request:
To authorize the County of Riverside to discuss with the person(s) identified in #2 details of my eligibility, enrollment and payment of premiums for County of Riverside sponsored health plans.

5). Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying the COUNTY OF RIVERSIDE BENEFITS DIVISION in writing at: 4080 LEMON STREET, FIRST FLOOR, RIVERSIDE, CA 92501. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation.

6). I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

7). I understand that I am entitled to receive a copy of this authorization.

8). This authorization will expire on:
_____
(Enter the date or event this authorization will expire.)

_____ _____
Signature *(required)* Date *(required)*

If a Personal Representative executes this form, the Representative warrants that he or she has authority to sign this form on the basis of (proof of Representative authorization may be required):

_____