COUNTY OF SAN DIEGO
TEMPORARY EMPLOYEE ENROLLMENT/CHANGE FORM

Return completed form to the Employee Benefits Division via email: DHRBenefits.FGG@sdcounty.ca.gov or Fax 858-467-9708 or Mail Stop: 0-7

EMPLOYEE INFORMATION

Employee ID	Last Name	First Name	Middle Initial	Date of Hire

Home Address	City	State	Zip Code	Phone

Reason	Date of Enrollment Event	Email Address:
Open Enrollment	1/1/2025	

COVERAGE SELECTION – Indicate the level of coverage in which you wish to enroll or make coverage changes.

MEDICAL PLAN	
☐ Employee Only	☐ Kaiser Permanente High Deductible Health Plan
☐ Employee + One Dependent	☐ UnitedHealthcare Harmony High Deductible Plan
☐ Employee + Two or More Dependents	

Supporting documentation is required as proof of relationship to add new dependents: Spouse - Marriage Certificate; Children – Birth Certificate or Court Documents; Domestic Partner - Affidavit or Certificate of Domestic Partnership. If you have additional dependents, please continue on separate page.

Name of Employee and Dependent(s) (Last, First, MI)	**Please select Relationship type** Spouse / Child / Domestic Partner	**Gender** M / F	**Date of Birth**	**REQUIRED - Social Security Number *For a Newborn, please provide once obtained**	**Medical** Add / Drop

Premium Collection
Premiums will be collected each pay period through payroll deductions.

In the event that payroll deductions cannot be taken, a direct billing notification will be mailed to the address on file, allowing participants 30 days to pay. Check or money orders should be payable to "COUNTY OF SAN DIEGO INSURANCE FUND" and sent to the Employee Benefits Division, 5530 Overland Avenue, STE 210, San Diego, CA 92123. Please indicate "FOR MEDICAL INSURANCE" and include your Employee ID Number on your check to assure proper credit to your account. Payments will not be accepted in-person. If payment is not received within the 30 day window, coverage will be terminated effective the end of the month of the last full payment on file.

Authorization/Acknowledgment

1. **Deduction Authorization:** I hereby authorize the County take any applicable before-tax and after-tax deductions from my salary and to pay such sums as are due to selected carriers. This authorization shall apply to any increase or decrease due to the County and is to continue in effect until coverage or employment is terminated. Coverage and payment obligation are effective through the calendar month in which termination of coverage or employment occurs.
2. **Acknowledgment of Release of Enrollment/Change Information**: You authorize The County to transmit your enrollment and any dependent(s) demographic data to the plans in which you are enrolling or changing coverage.
3. **Dependent Coverage:** I hereby certify that the individuals listed on this enrollment form, if any, meet all the individual plans eligibility requirements.
4. **Arbitration Provisions:** *PLEASE READ CAREFULLY - Please read and sign the corresponding carrier plan's Arbitration Agreement in which you and your dependent(s) are requesting a change or enrollment of coverage.* ***SIGNATURE REQUIRED on the back of this form.***

MY SIGNATURE ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE AUTHORIZATION/ACKNOWLEDGEMENT. Employee Signature _____ Date _____

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.

SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN

My signature below indicates that I have carefully read the above "Binding Arbitration" language and agree to its terms.

Employee Signature _____Date_____

UnitedHealthcare Health Plan Arbitration Agreement

I **agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and 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 claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates , shall be determined by submission to binding arbitration. Any such dispute will note be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review or arbitration proceedings. All parties to this agreement are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.**

SIGNATURE REQUIRED FOR UNITEDHEALTHCARE HEALTH PLAN

My signature below indicates that I have carefully read the above "Binding Arbitration" language and agree to its terms.

Employee Signature _____ Date_____