



2010 COBRA ENROLLMENT/CHANGE FORM

Only complete this form if you would like to make Open Enrollment changes effective January 1st, 2010.

COVERAGE

- HEALTH
- DENTAL
- VISION
- EAP

COVERAGE LEVEL

- FAMILY
- FAMILY
- FAMILY
- FAMILY

- SINGLE
- SINGLE
- 1 DEPENDENT
- SINGLE
- SINGLE

KAISER PERMANENTE – Group #887
 BLUE SHIELD HMO – Group #H11756
 BLUE SHIELD POS – Group #MH0161
 BLUE SHIELD PPO – Group #975567

BLUE SHIELD HMO/POS Provider #: _____
 Location: _____

DELTA DENTAL PPO – Group #2584
 DELTACARE HMO – Group #5643
 Dental Provider #: _____

VSP VISION – Group # 12112926
 EYEMED VISION CARE - Group # 9681586
 EYEMED MATERIALS-ONLY - Group # 9721127

Form must be received by 12/11/2010. Mail to 200 E. Santa Clara St. 2nd Fl. Wing, San Jose, CA 95113 or fax to (408) 999-0862.

EAP (Employee Assistance Program)

COBRA Primary Participant Information:

Social Security Number	Last Name	First Name	M.I.	Date of Birth
Address		City	State	Zip
Telephone Number		City Department		<input type="checkbox"/> Male <input type="checkbox"/> Female
Home ()	Work ()	Other ()		<input type="checkbox"/> Single <input type="checkbox"/> Married

REQUEST TO COVER DEPENDENTS

	Last Name	First Name	Date of Birth	Social Security Number	M or F	Relationship ID # (See below)	Age 19 - 23 FT Student Status?		Please <u>circle</u> the benefit plan type(s) you would like to enroll each dependent.
Spouse/Dom. Partner									Health Dental Vision EAP
Child							Yes	No	Health Dental Vision EAP
Child							Yes	No	Health Dental Vision EAP

Are you or your dependent(s) covered under another: **Health plan:** Yes No **Dental Plan:** Yes No **Vision Plan:** Yes No

- Relationship ID #**
- 01 - Husband
 - 02 - Wife
 - 03 - Domestic Partners
- Date of Marriage/ Domestic Partnership**
- Son**
- 04 - Your natural child
 - 05 - Your spouse's child
 - 06 - Child of your Domestic Partner
 - 07 - Court-ordered Guardianship
 - 08 - Legally adopted child
- Daughter**
- 09 - Your natural child
 - 10 - Your spouse's child
 - 11 - Child of your Domestic Partner
 - 12 - Court-ordered Guardianship
 - 13 - Legally adopted child

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.

 Kaiser COBRA Primary Participant Signature Date

I authorize my health plan carrier to release or obtain medical information on myself and covered dependents to or from health care providers/agencies for the purpose of providing necessary health care services, utilization review, quality assurance, surveys, processing of claims, financial audit or purposes reasonably related to the performance of the agreement or policy. I also agree to be bound by the benefits, limitations, exclusions and other terms of the Group Agreement and any amendments to the Group Agreements. I understand that only my legal dependents, as defined by the City of San José, may be enrolled in my health, dental, and vision, and EAP plans. I declare that all the information provided herein is true and correct.

COBRA Primary Participant Signature: _____ Date: _____