HEALTH BENEFITS ENROLLMENT APPLICATION: COMMISSIONERS FOR JANUARY–DECEMBER 2025 PLAN YEAR

You must submit a completed enrollment application and required eligibility documents to the San Francisco Health Service System (SFHSS) **within 30 days** of your initial benefits eligibility date, qualifying life event (QLE), or within the Open Enrollment (OE) period. Refer to your Benefits Guide or visit **sfhss.org** for more details.

1 APPLICATION TYPE

☐ New Hire ☐ Open Enrollment

QUALFYING LIFE EVENTS (Select One)

☐ Birth/Adoption ☐ Marriage/Partnership ☐ Separation/Dissolution/Divorce
☐ Ineligible ☐ Other Coverage ☐ Other _____

2 YOUR PERSONAL INFORMATION

Last Name	First Name	Initial	DSW

Street Address (no P.O. Boxes)	City	State	Zip Code

Social Security Number (SSN)	Birth Date MM/DD/YYYY	Gender M/F	Home/Cell Telephone Number

Email Address	Work Telephone Number

3 YOUR MEDICAL PLAN (includes Basic VSP)[2]

☐ Trio HMO[1] (Blue Shield) ☐ Access+ HMO[1] (Blue Shield)
☐ Kaiser Permanente HMO[1] ☐ Blue Shield of CA PPO
☐ Waive Medical Coverage ☐ Health Net CanopyCare HMO[1]

4 YOUR DENTAL PLAN

☐ Delta Dental PPO ☐ Deltacare USA DHMO[1]
☐ UnitedHealthcare Dental DHMO[1]
☐ Waive Dental Coverage

5 VISION PLANS

☐ VSP Basic Plan[2] ☐ VSP Premier Plan[3]

If you are currently enrolled in the VSP Premier Plan, you and your dependents will automatically be re-enrolled in the VSP Premier Plan next year. If you do not wish to re-enroll in VSP Premier, check the VSP Basic Plan box.

[1]To enroll in an HMO/DHMO Plan, you must live in an area serviced by the HMO/DHMO. [2] Enrollment in any medical plan automatically includes enrollment in the VSP Basic Vision Plan. [3]VSP Premier Plan is an additional cost. To enroll in this plan, you and your dependents must be enrolled in a medical plan and all dependents must also enroll in the VSP Premier Plan.

6 TO ADD OR DROP DEPENDENTS FROM YOUR MEDICAL AND/OR DENTAL COVERAGE, PLEASE LIST BELOW.

You must submit required eligibility documents for the initial enrollment of any dependents. See the reverse side of this form for more information.

Medical	Dental	Last Name	First Name	Birth Date	Gender M/F	SSN	Relationship
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐						

7 SALARY REDUCTION AGREEMENT & SIGNATURE

Under penalty of perjury I certify that the information entered on this document is true and correct. I hereby authorize and direct my employer to reduce my salary in the amount necessary to pay for any allowed pre-tax coverage. Such reductions, considered as elective contributions under the plan shall commence on the first payroll cycle that my coverages go into effect. I understand that the purpose of this program is to allow employees to select their qualified benefits within the guidelines of Section 125 of the Internal Revenue Code. Coverages allowed by this code include medical, dental, and vision. **I have read and accept the terms and conditions on this side and the reverse side of this form**. A copy of this form is as valid as the original.

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

If you have selected the Kaiser Plan, by submitting your enrollment application, you are agreeing to Kaiser 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: Date:

Mail or drop off this form in person to: SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103 • SFHSS Member Services Phone: (628) 652-4700.
Fax forms to: (628) 652-4701 • **Please do not fax the same application multiple times.** • **Keep a copy of this form for your records.**

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:

- The San Francisco Health Service System (SFHSS) will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- You agree to complete and submit to the plan provider any necessary forms, consents, releases, assignments, applications, questionnaires and other documents that the plan or SFHSS may reasonably request.
- **You understand that your elections will remain in effect and cannot be revoked or changed until the next Open Enrollment period unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of spouse, etc.) as listed in the SFHSS Rules.**
- You agree to submit any contribution required on your part directly to SFHSS during any unpaid leave of absence, or if your pay is insufficient to cover the cost of the premium payments.
- Your participation in the SFHSS benefits is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of SFHSS as the same may be amended, modified or supplemented from time to time).
- Any misrepresentation of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to reimbursement of premium and claims costs on a retroactive basis, disciplinary action, including dismissal and/or legal action.
- The terms and conditions of each medical/dental plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by SFHSS, the terms and conditions of the plan documents will govern.
- You understand that **some of the health plans offered by SFHSS contain a clause requiring resolution of medical malpractice and other disputes through binding arbitration**. This clause expressly provides that when you select the applicable plan, you give up the right to a jury or court trial for resolution of these disputes. To determine whether the plan you have selected contains such a clause and, if so, what the exact terms and conditions of such clause are, consult the individual plan document available through applicable plan provider.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through SFHSS, you will promptly notify SFHSS and submit all requested documentation. Eligibility of dependents may be audited at any time and require submission of documentation that substantiates and confirms that the dependent's relationship with the employee or retiree is current.
- All healthcare services provided or benefits paid on behalf of any ineligible employee, retiree, or dependent are subject to collection by the health plan involved or by SFHSS.
- The following eligibility documents are required, in addition to a completed Health Benefits Enrollment Application, for any eligible individual's enrollment. SFHSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTS

	CERTIFIED MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	SOCIAL SECURITY #
Employee: Permanent/Provisional							■
Employee: Temporary/Exempt							■
Spouse	■						■
Domestic Partner		■					■
Child: Natural			■				■
Step Child: Spouse	■		■				■
Step Child: Domestic Partner		■	■				■
Child: Adopted				■			■
Child: Placed for Adoption					■		■
Child: Legal Guardianship (Up to Age 19)						■	■
Child: Court Ordered (Up to Age 19)						■	■
Adult Child: Disabled			■				■

Proof of Medicare enrollment is also required for a registered domestic partner who is Medicare eligible due to age or disability.
Please visit sfhss.org for full eligibility requirements.