SHARP HEALTH PLAN | SAN DIEGO PEBA

## Non-Medicare / Early Retiree

# Enrollment Application

### Eligibility requirements for non-Medicare retirees

- ☑ Be a City of San Diego retiree or a spouse and / or dependent of that person.
- ☑ Live in the Sharp Health Plan service area (San Diego and southern Riverside counties).

**Please Note:** Membership in MEA, REA, RFPA or SDPEBA is **not** required.

### Instructions

Answer all questions and fill in check boxes with an X.

- Sign the form on page 3 and date it. Be sure you have read all the pages before you sign.

### Submit

Please submit the finished form by mail, in person, fax or email:

**By mail or in person:**
San Diego Public Employee Benefit Association (SDPEBA)
9620 Chesapeake Dr., Suite 104
San Diego, 92123

**By fax:**
(619) 431-3078

**By email:**
support@sdpeba.org

**If you need assistance, we're here to help.**
You can call SDPEBA at 1-888-315-8027.

### Employer use only

| Group name: | Group number: | Effective date (MM/DD/YY): |
|---|---|---|
| San Diego Public Employee Benefit Association (SDPEBA) | 1006268 | / / |

### Plan selection

☐ Classic Plan (Non-Medicare / Early Retiree) 20/20/100 ☐ Select Plan (Non-Medicare / Early Retiree) 20/30/500

### Indicate coverage below (check one coverage level)

☐ Retiree only ☐ Retiree and spouse / domestic partner ☐ Retiree and child ☐ Retiree and children ☐ Retiree and family

### Reason for this application

☐ New enrollee
☐ Open enrollment
☐ Name change (list change below)
☐ Address or phone change (list change below)
☐ Add dependent coverage (list name(s) below)
☐ Delete dependent coverage (list name(s) below)
☐ Primary Care Physician change (list change below)
☐ Termination (coverage end date MM/DD/YY)
_____ / _____ / _____

### Employee information

| Are you the City of San Diego retiree? ☐ Yes ☐ No If "No" please complete → | Retiree name (Last, First, Middle initial): |
|---|---|

Are you the surviving spouse of a City of San Diego retiree? ☐ Yes ☐ No

## Employee information, continued

| First name: | Last name: | Middle initial: | Sex: ☐ M ☐ F |
|---|---|---|---|

| Social Security number: – – | Birth date: MM/DD/YY / / | Marital status: ☐ Single ☐ Married ☐ Widowed<br>☐ Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency)<br>☐ Non-Registered Domestic Partnership (requires employer approval) |
|---|---|---|

| Home phone number: ( ) | Alternative phone number: ( ) | Email address: | Preferred language: |
|---|---|---|---|

| Home address (P.O. Box is not allowed): | | |
|---|---|---|
| City: | State: | ZIP code: |

## Primary Care Physician information (if left blank, Sharp Health Plan will assign)

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findadoctor** or call Customer Care at 1-800-359-2002.

| Primary Care Physician name: | Provider NPI: | Are you an existing patient with this doctor? ☐ Yes ☐ No |
|---|---|---|

## Dependent information

| Last name, first name, M.I. | Social Security | Date of birth MM/DD/YY | Sex | Primary Care Physician (if left blank, Sharp Health Plan will assign) | Existing patient? |
|---|---|---|---|---|---|
| Spouse:<br>Date of marriage: | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |
| Domestic partner:<br>Affidavit submitted?<br>☐ Yes ☐ No | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |
| Child: | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |
| Child: | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |
| Child: | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |
| Child: | | / / | ☐ M<br>☐ F | | ☐ Yes<br>☐ No |

## Other medical coverage

Do you or your dependents intend to continue other medical or Medicare coverage? ☐ Yes ☐ No

If "Yes" complete the following: ☐ Self ☐ Spouse ☐ Dependent

| Name of insured: | Dependents enrolled with other medical coverage: | |
|---|---|---|
| Name of other Insurance Company: | Group number / Policy number: | Coverage start date: MM/DD/YY / / |

## Disclosures and signatures

**Please read the following carefully before signing.**

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application.

## Arbitration Agreement

I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

**Acknowledgment**

I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Sharp Health Plan.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

**Authorization to obtain or release medical information**

Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act, Section 56 et seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp Health Plan, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation, or evaluation of any application or a claim. I authorize Sharp Health Plan, or agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for 30 months to permit evaluation of this application, or for the term of coverage to allow the processing of claims. A photocopy of this authorization shall be as valid as the original.

**Misrepresentation**

I have read and understood the provisions outlined on the front and back of this form. All information I have provided on this form is true and correct. 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 the policy being rescinded. I understand that I am entitled to a copy of this signed Early Retiree (Non-Medicare) Enrollment Application and Authorization.

| Employee signature: | Date: MM/DD/YY |
| --- | --- |
| X | / / |