Scripps Health Plan

Employee Enrollment Form

Group Name:	Group Number:
Class A:	Class B:

Section A: ******EMPLOYER USE ONLY******

Purpose

☐ New Employee ☐ Open Enrollment ☐ Employee Termination ☐ Add/Remove Dependent(s) ☐ Convert to COBRA / Cal-COBRA*

☐ Benefit Status Change *(explain):*_____ **(Complete **Section E** if enrolling in a COBRA plan)*

Effective Date ____/____/_____ **Reason:** _____

Section B: Employee Information

Social Security Number	Name (Last, First, MI)		Home Phone
Home Address	Apt No.	City, State	Zip
Employer Name			Work Phone
Employer Address		City, State	Zip

Preferred Language: ☐ English ☐ Español ☐ Other:_____

Section C: Plan Options

Select a Medical Plan	**Select a Prescription Drug Plan**
☐ Scripps Health HMO	☐ Scripps HMO Prescription Drug Plan
Plan Description:	**Plan Description:**

Section D: Covered Individuals **(see instructions below if you answer **Yes** to any of the following)*

☐ Add ☐ Change ☐ Remove	1.) Employee Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage?	Other Rx Drug Coverage?	Physically or Mentally Disabled	Primary Care Physician ID#
	☐ YES*	☐ YES*	- Not Applicable -	

☐ Add ☐ Change ☐ Remove	2.) Spouse Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage?	Other Rx Drug Coverage?	Physically or Mentally Disabled	Primary Care Physician ID#
	☐ YES*	☐ YES*	☐ YES*	

☐ Add ☐ Change ☐ Remove	3.) Child Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage?	Other Rx Drug Coverage?	Physically or Mentally Disabled	Primary Care Physician ID#
	☐ YES*	☐ YES*	☐ YES*	

☐ Add ☐ Change ☐ Remove	4.) Child Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage?	Other Rx Drug Coverage?	Physically or Mentally Disabled	Primary Care Physician ID#
	☐ YES*	☐ YES*	☐ YES*	

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Section D: Covered Individuals [Continued] ***(see instructions below if you answer **Yes** to any of the following)***

☐ Add ☐ Change ☐ Remove	5.) Child Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage? ☐ YES*	Other Rx Drug Coverage? ☐ YES*	Physically or Mentally Disabled ☐ YES*	Primary Care Physician ID#

☐ Add ☐ Change ☐ Remove	6.) Child Name (Last, First, MI)	Sex	Date of Birth (mm/dd/yyyy)

Social Security Number	Other Medical Coverage? ☐ YES*	Other Rx Drug Coverage? ☐ YES*	Physically or Mentally Disabled ☐ YES*	Primary Care Physician ID#

Section E: COBRA and Cal-COBRA

Coverage for ☐Employee ☐Dependent(s) **Length of Continuations** (in months) ☐18 ☐36 ☐Other:_____

Date of Qualifying Event____/____/_____ ☐29 *(attach disability determination from SSA)*

Continuation of Coverage Expiration Date ____/____/_____

If you answered **YES** *to* **Other Medical Coverage** *or* **Other Rx Drug Coverage** *above, please complete the form "Coordination of Benefits" and submit copies of benefit ID cards.*

Section F: Additional Information

Do any of the above listed dependents reside at a different address than the employee? ☐ No ☐ Yes
*(if **Yes** with whom and where? Briefly explain circumstances)*

Section G: Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

Application Acknowledgement & Agreements

On behalf of myself and the dependents listed on this form, I agree to or with the following:

1.) I acknowledge that by enrolling in the following plans coverage is provided by Scripps Health Plan Services (heretofore "the plan")
2.) I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for my coverage.
3.) The plan documents (Schedule of Benefits, Group Agreement, Evidence of Coverage, amendments, riders or endorsements) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4.) I understand and agree that the plan's participating providers are independent contractors and are neither agents nor employees of the plan. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of changes to the plan's provider network will be made in accordance with state law.
5.) I understand and agree that with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that in order to be covered, services must be performed by either a participating primary care physician, or by a participating specialist, hospital, pharmacy or other providers authorized by a referral from a primary care physician.

Section H: Statement of Misrepresentations

ATTENTION CALIFORNIA RESIDENTS – For your protection, state law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Section I: Employee Acknowledgement

To the best of my knowledge, I represent that all the information supplied in this form is true and complete. I have read and agree to the "Conditions of Enrollment" and the "Statement of Misrepresentations" on this Enrollment / Change Request Form.

NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP MAY BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS PROVIDED FOR IN CALIFORNIA UNDER JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that by signing below I am WAIVING my constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that I will not be allowed to try a case in court. I further understand that the Plan agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

If you have questions concerning the benefits provided by or excluded under this Agreement, contact a member services representative at 1 (844) 337-3700 between 8am-5pm.

Section J: Authorization to Obtain or Release Medical Information

Scripps Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act. §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 Scripps 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 Scripps 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.

Section K: Employee Signature

Employee Signature	**Date (Month / Day / Year)** ___/___/___
Email Address (optional)	**Primary Language**

Section L: Declination of Coverage ***COMPLETE ONLY IF YOU WISH TO *DECLINE* COVERAGE***

I have been notified that I and/or my eligible dependents, are eligible for enrollment in my employer's health benefits plan. By listing individuals for whom I am declining coverage and signing below, **I voluntarily decline to enroll myself and/or those individuals and acknowledge that my decision not to elect coverage permits my employer's health benefit plan to impose a 12-month exclusion from coverage following application, or until open enrollment, should I or these individuals later apply for coverage**

Name (Last, First, MI)	Enter 1 or 2	1 – Individual declining coverage **DOES NOT** have another employer health benefit plan 2 – Individual declining coverage **DOES** have another employer health benefit plan.
Name (Last, First, MI)	Enter 1 or 2	
Name (Last, First, MI)	Enter 1 or 2	
Name (Last, First, MI)	Enter 1 or 2	X SIGN HERE ONLY IF DECLINING HEALTH COVERAGE

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– INSTRUCTIONS –

Section B: Employee Information
Complete all information, including your current home address and employer information.

Section C: Plan Options
Select one medical benefit plan and one prescription drug benefit plan and provide the description of the plan you elect. Your employer may have restrictions on offered benefits. Contact your HR benefits coordinator for more information.

Section D: Covered Individuals
Complete all information for the individuals who you wish to add, change or remove benefit coverage.

- *Add / Change / Remove* – Mark if you are adding, changing, or removing coverage for the named individual.
- *Name, Sex, DOB & SSN* – Print your full name (Last, First Middle Initial) along with the name of your spouse and any dependent(s). Indicate Sex, Date of Birth (mm/dd/yyyy), and Social Security Number for each individual.
- *Other Medical Coverage?* – If you, your spouse or your dependent(s) have other medical coverage (such as from a spouses employer, disability health insurance, government insurance programs, etc.) check Yes and provide the effective date, policy name and the member ID number. *Don't forget to provide a copy of your benefits card.*
- *Other Rx Drug Coverage?* – If you, your spouse or your dependent(s) have other prescription drug coverage (such as from a spouses employer, government prescription drug benefit, etc.) check Yes and provide the effective date, policy name and the member ID number. *Don't forget to provide a copy of your benefits card.*
- *Physically or Mentally Disabled?* – If your spouse or dependent(s) have a physical or mental disability and is financially dependent, check Yes and provide proof of physical or mental disability from the primary physician.
- *Primary Care Physician ID Number* – Locate the ID number for your primary care physician (PCP) from the provider directory provided by your benefits coordinator or the online provider directory at www.scrippshealthplan.com. If you do not indicate a PCP, a provider will be assigned to you. You have the option to change your PCP at any time by contacting the plan or your IPA.

Section E: COBRA / Cal-COBRA
Complete this section if you qualify or are applying to qualify for COBRA and/or Cal-COBRA coverage.

Section F: Additional Information
If a covered individual resides at a *different* address than you, check Yes, list the individual, the address and a brief explanation.

Sections G - J: Plan Terms and Member Rights & Responsibilities
Please read these sections carefully – they describe your rights and responsibilities under the plan. By signing this form you acknowledge that you have read and understand these statements and agree to their terms. Please call you HR Benefits Coordinator if you have questions about this section.

Conditions of Enrollment
This section explains *your rights and responsibilities* under the plan, including payment of plan premiums.

Statement of Misrepresentations
This section states that you may be held criminally liable for reporting false claims or information.

Employee Acknowledgement
This section states you agree to submit to binding arbitration in the event a dispute arises between you and the plan.

Authorization to Obtain or Release Medical Information
This section allows the plan to request and disseminate your medical information in accordance with state and federal law.

Section K: Employee Signature
Provide your signature and today's date. If you provide your email address, you agree to receive email communications about the plan. Provide the language in which you wish to receive communication from the plan.

Section L: Declination of Coverage
Complete this section ONLY if you wish to DECLINE COVERAGE that has been offered by your employer for you and any eligible dependents. ***If you decline, you may have to wait up to 12 months to qualify for benefits under the plan***. Speak with your HR Benefits Coordinator about questions related to declining coverage. If you choose to decline coverage, list yourself and any eligible dependents for whom you are declining coverage. Enter a **1** if the individual **does not** have another health benefit plan. Enter a **2** if the individual **does** have another health benefit plan.