SYNOD of the Pacific Benefits ENROLLMENT FORM November 1, 2015 – October 31, 2016

Employee Information					
Church/Organization Name	Location (ie City/State)		Date of Hire		
Job Title	Number of hours per week		Social Security Number		
Employee Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Gender ☐ M ☐ F	Marital Status ☐Single ☐Married ☐Domestic Partner	Children ☐ Yes ☐ No	
Home Address	Apt. #	City, State, Zip	Phone Number	**Coverage Effective Date:**	
Email Address (important for Synod Benefits correspondence):					

Enrollment Type (Please select all that apply)

☐New Enrollment
☐Re-Hire Date: _____
☐Open Enrollment
☐Marriage, Event Date: _____
☐ Part-time to Full-time Employment Date: : _____
☐ Family Addition
☐ Change
☐ Other Qualifying Event: _____

Medical Enrollment Information		
Anthem Blue Cross PPO Anthem Blue Cross ☐ California #165970M033 ☐ Out of California #165970M036 (BC)	HRA Anthem Blue Cross ☐ California #165970M026 ☐ Out of California #165970M036 (BC)	HMO Anthem Blue Cross ☐ California Only #165970H001
Kaiser Permanente ☐ HMO Kaiser Permanente (602931) "California" ☐ Enrollment Unit # _____	☐ HMO (Outside California) Kaiser Permanente (04575) "Northwest" ☐ Enrollment Unit #_____	☐ HRA Kaiser Permanente (602931) "California" ☐ Enrollment Unit #_____

Medical Coverage Selection		
☐ Waive Coverage	☐Employee Only	☐Employee + Spouse/DP
☐ Employee + Child(ren)	☐Employee + Spouse/DP & Child(ren)	

Assurant Dental Group Number K1900860/1		
☐Waive Coverage	☐Low Option Dental	☐High Option Dental

Assurant Dental Coverage Selection		
☐Employee Only	☐Employee + 1 Dependent	☐Employee + 2 or more dependents

Assurant Vision Group Number 5465207		
☐Waive Coverage	☐Core Vision	☐Buy-Up Vision

Assurant Vision Coverage Selection		
☐Employee Only	☐ Employee + 1 Dependent	☐ Employee +2 or more dependents

Anthem Blue Cross Basic Life (Group Number 165970-0001) and AD&D (Group Number 165970-0002) (Employer Paid, for Anthem enrollees only) Flat $15,000 Benefit		
☒Employee Only	☒ Flat dollar benefit Basic Life – 1659700001	☒ Flat dollar benefit Basic AD&D – 1659700002

Assurant Basic Life and AD&D (Employer Paid, for Assurant Dental enrollees only)
☒Employee Only

Dependent Information ☐ **Spouse** ☐ **Domestic Partner**				**Anthem HMO Enrollees Only**
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
Elected Coverage:☐Medical ☐Dental ☐Vision				Is this your current MD? ☐Yes ☐No

Child(ren)				**Anthem HMO Enrollees Only**
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
If Children are age 26 or over, you must select one of the following: ☐Qualifies as IRS Dependent ☐Totally Disabled				Is this your current MD? ☐Yes ☐No
Elected Coverage: ☐Medical ☐Dental ☐Vision				
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
If Children are age 26 or over, you must select one of the following: ☐Qualifies as IRS Dependent ☐Totally Disabled				Is this your current MD? ☐Yes ☐No
Elected Coverage: ☐Medical ☐Dental ☐Vision				
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
If Children are age 26 or over, you must select one of the following: ☐Qualifies as IRS Dependent ☐Totally Disabled				Is this your current MD? ☐Yes ☐No
Elected Coverage: ☐Medical ☐Dental ☐Vision				
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
If Children are age 26 or over, you must select one of the following: ☐Qualifies as IRS Dependent ☐Totally Disabled				Is this your current MD? ☐Yes ☐No
Elected Coverage: ☐Medical ☐Dental ☐Vision				
Name (Last, First, MI)	D.O.B. (Mo/Day/Yr)	Sex ☐M ☐F	Social Security No.	Anthem HMO Primary Physician/ IPA Code:
If Children are age 26 or over, you must select one of the following: ☐Qualifies as IRS Dependent ☐Totally Disabled				Is this your current MD? ☐Yes ☐No
Elected Coverage: ☐Medical ☐Dental ☐Vision				

Prior Health Coverage Information (for Anthem PPO dependent children over 26 only)

- ☐ Names of persons with prior coverage: ______________________________
- ☐ Coverage begin date: ______________________________
- ☐ Coverage end date: ______________________________
- ☐ Carrier name: ______________________________
- ☐ Reason for ending coverage: ______________________________

Other Health & Dental Coverage (complete only if electing coverage)

Name	Relationship	Other Coverage	Start Date	Carrier Name & Group Number	Primary Coverage
		☐Yes ☐No			☐Yes ☐No
		☐Yes ☐No			☐Yes ☐No
		☐Yes ☐No			☐Yes ☐No
		☐Yes ☐No			☐Yes ☐No
		☐Yes ☐No			☐Yes ☐No

Please complete if you want to decline Health coverage for yourself and/or any eligible dependents:
Reason for declining: (Proof of coverage may be required) Answers are for Medical Plans

☐Covered by another employer-sponsored group plan; carrier name is _____

☐Covered by Individual Policy

☐Covered by Medicare

☐Covered by Medi-Cal

☐Enrolled in any other insurance carrier plan; name:_____

☐Other

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.

Signature if declining coverage for employee/dependent(s) Date

BASIC LIFE BENEFICIARY DESIGNATION (for Anthem and Assurant Enrollees ONLY):

Primary 1 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address (Street, Apt. #, City, State, Zip)			Percentage
Primary 2 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address (Street, Apt. #, City, State, Zip)			Percentage
Contingent 1 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address (Street, Apt. #, City, State, Zip)			Percentage
Contingent 2 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address (Street, Apt. #, City, State, Zip)			Percentage
Other (Estate of Insured, Revocable or Irrevocable Trust and Trustee under insured's will)			
Address (Street, Apt. #, City, State, Zip)			Percentage

AUTHORIZATION: To be signed by all employees applying for Assurant Dental Coverage

My signature on this application certifies that I :
(1)Apply for coverage designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverage has been refused, I am not entitled to benefits under that coverage and that if I want to apply later, I understand I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. (3) Authorize any requirement deductions from my earnings. (4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (5) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured. (6) Understand that I have the right to select any dental care provider of my choice. (7)Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed. (8) When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.
For your protection California law requires the following to appear on the 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.

This will certify that <u>I HAVE</u> read and understand the above important notice.

Employee Signature **X**	**Date**

AUTHORIZATION: To be signed by all employees applying for KAISER PERMANENTE Coverage

<u>Kaiser Foundation Health Plan Arbitration Agreement</u>
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 the Kaiser Permanente Plan **X**	**Date**

AUTHORIZATION: To be signed by all employees applying for Anthem Blue Cross Coverage

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.
DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.
NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

W–9 Certification Language
As part of the W–9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

X

Employee Signature (Required for Anthem Enrollees) **Date**

The information I have provided is, to the best of my knowledge, true and correct. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provision without written approval from the insurance carriers, on behalf of myself and my covered Dependents.

X

Employee/Subscriber Signature **Date**