CITY OF BERKELEY | **MEDICAL and DENTAL BENEFIT CHANGE/ENROLLMENT FORM**

EMPLOYEE	Social Security Number	Birth date	Gender	Hire Date	% time
			☐M ☐F		
Last First MI					
Street address City State Zip			Phone		Work phone

☐ **New Enrollment** ☐ **Change Enrollment** **Event date:**

Sutter Health Plus ONLY Participating Physician Group # & Primary-Care Physician Name

☐Kaiser & Delta ☐Sutter Health Plus & Delta ☐Kaiser only ☐Sutter Health Plus only ☐ Delta only

Reason for change
Documents with proof of relationship or event date are required for all changes.

☐Marriage ☐Domestic partnership ☐Delete dependent ☐Other
☐Birth/Adoption ☐Legal guardianship ☐Divorce
☐Loss of other coverage ☐Term Domestic Partnership

Spouse/domestic partner name ☐ Spouse ☐ Domestic Partner	Add or Delete?	**F**emale or **M**ale?	Birthdate	Social Security #	**Sutter Health Plus ONLY** Participating Physician Group # & Primary-Care Physician Name
Last First MI					

Address if different than employee:

Dependent Name(s) Last if different	First	MI	Add or Delete?	**F**emale **M**ale?	Is child disabled?	Birthdate	Social Security #	**Sutter Health Plus ONLY** Participating Physician Group # & Primary-Care Physician Name

I hereby affirm, under penalty of perjury, that all of the information entered is true and correct to the best of my knowledge. I also understand that any false information entered will make this enrollment process and the coverage for which it applies null and void. The Plan reserves the right to rescind coverage should the information prove to be incomplete or inaccurate. I understand that I must notify the Human Resources Department within 30 days of experiencing a qualifying event and I must complete any applicable paperwork. I authorize the City of Berkeley to make all payroll deductions associated with my elections on a pre-tax basis. Some exceptions to the pre-tax rule may apply. I understand that I am entitled to a copy of the plan documents for the benefit plans and can access these plans at the BenefitBridge website or by request to the Human Resources Department.
My signature affirms that I have read the individual plan agreements on the reverse side of this form and agree to all conditions of the individual carriers and the terms of the group contract.

Employee Signature Date

OFFICE USE ONLY	DEPENDENT VERIFICATION DOCUMENTS	Verified by:	Effective Date:
☐Marriage Certificate ☐Birth Certificate(s)/Adoption docs ( ) ☐ Legal Guardianship docs ☐DP and/or IRS Affidavit ☐Loss of Other Coverage docs ☐Other			
Entered in BenefitBridge date:	KAISER HMO 60-0000 SUTTER HEALTH PLUS 116006-000001 DELTA: 8367-0012; 8367-0015; 8367-0017		

SUTTER HEALTH PLUS

BINDING ARBITRATION: Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, 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 binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Evidence of Coverage and Disclosure Form.

KAISER

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.*