SHARP HEALTH PLAN

Customer Service
1-858-499-8301
1-888-840-4747

City of San Diego Non-Medicare Retiree Plan 15/15/100

This plan is open to all City of San Diego Retirees, sponsored by MEA. Membership with MEA is not required to join this plan.

UNION MEA SINCE 1926

INDICATE COVERAGE BELOW (CHECK ALL THAT APPLY)

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
- ☐ Change Name
- ☐ Change Address or Phone
- ☐ Add Dependent Coverage (List names below)
- ☐ Delete Dependent Coverage (List names below)
- ☐ Change Primary Care Physician

EFFECTIVE DATE

GROUP NAME	PLAN NUMBER
SAN DIEGO MUNICIPAL EMPLOYEES ASSOCIATION	**79173**

SOCIAL SECURITY NUMBER	NAME (Last, First, MI)	DATE OF BIRTH (MM/DD/YY)	(PREFERRED LANGUAGE)	GENDER
				☐ MALE ☐ FEMALE

HOME ADDRESS (Street and Number)	CITY	STATE	ZIP CODE	MARITAL STATUS
				☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOW(ER)

HOME PHONE NO.	ALT PHONE NO.	E-MAIL
( )	( )	

PRIMARY CARE PHYSICIAN (Full Name—If left blank, plan will assign)	PCP OFFICE LOCATION	EXISTING PATIENT?
		☐ YES ☐ NO

DEPENDENT INFORMATION

NAME (Last, First, MI)	RELATIONSHIP		GENDER	DATE OF BIRTH	SOC. SEC. NO.	F/T STUDENT?	PRIMARY CARE PHYSICIAN (Full Name)	EXISTING PATIENT?
	SPOUSE	DATE OF MARRIAGE				N / A		YES / NO
	DOMESTIC PARTNER	AFFIDAVIT SUBMITTED: YES / NO				N / A		YES / NO
	CHILD					YES / NO		YES / NO
	CHILD					YES / NO		YES / NO
	CHILD					YES / NO		YES / NO
	CHILD					YES / NO		YES / NO
	CHILD					YES / NO		YES / NO

OTHER MEDICAL COVERAGE

DO YOU OR YOUR DEPENDENTS HAVE OTHER MEDICAL OR MEDICARE COVERAGE? ☐ YES ☐ NO (If "Yes", Complete the Following) ☐ Self ☐ Spouse / Domestic Partner ☐ Child(ren)

NAME OF INSURED	DEPENDENTS ENROLLED WITH OTHER MEDICAL COVERAGE

NAME OF OTHER INSURANCE COMPANY	GROUP NO. / POLICY NO.	COVERAGE START DATE

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.

X _____ _____

EMPLOYEE SIGNATURE DATE

ACKNOWLEDGMENT

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. PLEASE READ CAREFULLY BEFORE SIGNING AT THE "X" ON THE REVERSE SIDE.

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 Enrollment Form and Authorization.

Mail completed forms to:

MEA's Benefits Department
P.O. Box 34547
San Diego, CA 92163