SAN DIEGO PEBA

2019 - 2020 Retiree Enrollment Form

Step 1: PERSONAL INFORMATION

Social Security Number** _____

Last Name _____ First Name _____ M.I. _____

D.O.B. ___/___/___ Gender: Male☐ Female☐ Marital Status: Single☐ Married☐ Divorced☐ Separated☐ Widow☐

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ SDCERS ID _____

E-mail _____ Retirement Date _____

**SDCERS requires a full SSN to initiate a pension deduction. If you prefer, you may write 'Please Call' on that line and one of our staff members will reach out to you directly to obtain the information.

Step 2: DENTAL

(Please choose one dental option. Rates are monthly)

☐ No Dental

Dental HMO - Select Facility on Reverse of this form

- ☐ Retiree Only - $21.00
- ☐ Retiree & Spouse/DP - $40.90
- ☐ Retiree & Child(ren) - $40.90
- ☐ Retiree & Family - $58.46

Dental PPO

- ☐ Retiree Only - $66.50
- ☐ Retiree & Spouse/DP - $124.50
- ☐ Retiree & Child(ren) - $143.00
- ☐ Retiree & Family - $208.50

Step 3: VISION

(Please choose one vision option. Rates are monthly)

☐ No Vision

VSP Vision

- ☐ Retiree Only - $18.50
- ☐ Retiree & Spouse/DP - $32.50
- ☐ Retiree & Child(ren) - $32.50
- ☐ Retiree & Family - $53.50

Step 4: HYATT LEGAL PLAN

Please note: If you are currently on the Hyatt Legal Plan & select 'No' your plan will terminate July 31, 2019

☐ NO Hyatt Legal Plan

☐ YES, Enroll Me - $23.40/month

Step 5: DEPENDENT INFORMATION

If you selected dependent coverage for dental and/or vision, please provide your dependent information on the reverse side of this application.

Step 6: MEMBERSHIP SELECTION

Which organization(s) are you a member of or wish to join?

☐ **MEA** ☐ **REA** ☐ **RFPA** ☐ **SDPOA**

Step 7: RETIREE SIGNATURE

Retiree Signature ***Date***

I, the above signed, understand that I will be responsible for all costs associated with the plan(s) I have selected. I also understand that these plans are a one year commitment and cannot be cancelled until the next open enrollment. I also understand that I am agreeing to be a member of one of the participating SDPEBA organizations, and agree to pay dues accordingly, and that dues are not deductible as a charitable contribution. I accept the terms and conditions on the reverse side of this application.

Step 8: SUBMIT ENROLLMENT FORM

Please return forms to: SDPEBA
9620 Chesapeake Dr, Suite 203-B
San Diego, CA 92123

OR

FAX
619.431.3078

OR

E-mail
info@sdpeba.org

If you have any questions on your benefits, please call us at 888.315.8027 or visit us online www.sdpeba.org

2a. DENTAL HMO FACILITY SELECTION

DENTAL HMO FACILITY SELECTION

To begin using services you **MUST** complete this section. You will **NOT** be auto assigned to a dental provider. If a provider is not selected at this time it will delay using benefits. Please provide the Facility ID, do not enter name of dentist. PPO enrollees do not need to complete this section.

First Choice: _____ Second Choice: _____

5a. DEPENDENT INFORMATION

DEPENDENT 1 Enroll in: ☐ Dental ☐ Vision SSN _____

First Name _____ M.I. _____ Last Name _____

D.O.B. ___/___/___ Gender: Male ☐ Female ☐ Relationship Spouse ☐ Domestic Partner ☐ Child ☐

DEPENDENT 2 Enroll in: ☐ Dental ☐ Vision SSN _____

First Name _____ M.I. _____ Last Name _____

D.O.B. ___/___/___ Gender: Male ☐ Female ☐ Relationship Spouse ☐ Domestic Partner ☐ Child ☐

DEPENDENT 3 Enroll in: ☐ Dental ☐ Vision SSN _____

First Name _____ M.I. _____ Last Name _____

D.O.B. ___/___/___ Gender: Male ☐ Female ☐ Relationship Spouse ☐ Domestic Partner ☐ Child ☐

For additional dependents, please submit additional forms

HEALTH PLANS TERMS AND CONDITIONS (MEDICAL, DENTAL OR VISION)

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that Health Care Providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to a Health Insurance Provider. The Health Insurance Provider may use and may disclose this information for purposes of treatment, payment and health plan operation, including but not limited to, utilization management, quality improvement, disease or case management programs. The Health Insurance Provider's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by the Health Insurance Provider. A copy of this Notice may be obtained on the Health Insurance Provider's web site or by calling the Health Insurance Provider's customer service number.

NOTICE: For your protection, California law requires 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. CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Insurance Providers, I, and any enrolled dependents, are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract. I have read and understand the terms and conditions, and by completing my enrollment through the Employee Self Service system indicates that the information I entered in my account is complete, true and correct, and I accept these terms.

Binding Arbitration Agreement: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et. seq.) I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Insurance Provider regarding the construction, interpretation, performance or breach of the Health Insurance Provider Group Policies, or regarding other matters relating to or arising out of the Health Insurance Provider Policies, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Insurance Providers are giving up their constitutional rights to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Insurance Provider involving claims for health services malpractice (that is, whether any health services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy.

SDCERS Payee Deduction Authorization Form

As a retiree (or retiree spouse/beneficiary) of the City of San Diego, I am receiving a retirement allowance from the San Diego City Employees' Retirement System (SDCERS). By signing this form, I authorize SDCERS to deduct the amount designated below from my monthly retirement benefit, and pay that amount to the San Diego Municipal Employees Association (SDMEA) which administers benefits as the San Diego Public Employee Benefit Association (SDPEBA). My deductions will show as SDPEBA on my pension check. I acknowledge and agree to the following:

Deductions will be made on a "post-tax" or after-tax basis.

SDCERS makes no representation regarding the tax liability or consequences of making these deductions from your monthly retirement benefit and has given you no tax advice concerning these deductions.

SDCERS is not responsible for the purpose of deductions or how the monies are used by the payee entity.

Your decision to allow this deduction is voluntary.

Retiree agrees that SDCERS, its trustees, agents, officers, employees, directors and assigns will not, under any circumstances, be liable for indirect, consequential, special or punitive damages arising out of any acts taken by SDCERS relating in any manner to this authorization. Retiree acknowledges that all assets SDCERS holds are held in trust for the benefit of its Members, Beneficiaries and Participants, and retiree waives the right to collect damages of any amount or nature from SDCERS, regardless of any negligence that could be imputed to SDCERS' because of the acts committed by employees or acts committed by subcontractors retained by SDCERS within the scope of services provided under this authorization.

This authorization is valid until you revoke it. You may stop the deduction at any time by contacting SDPEBA/MEA or SDCERS. SDPEBA/MEA will notify SDCERS via the monthly deduction report, and the deduction will end on the next cycle.

You represent that you have read this form, accept the statements listed, and authorize SDCERS to make the monthly deduction.

Print name: _____ Signature: _____

SSN (last four digits): _____ Date: _____

Monthly deduction amount: _____