



CUSTOMER SERVICE
 858-499-8301
 888-840-4747

Early Retiree (Non-Medicare) Plan 20/20/100 for The City of San Diego

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



INDICATE COVERAGE BELOW (CHECK ALL THAT APPLY)		REASON FOR THIS APPLICATION			
Check One Coverage Level: <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree and Spouse / Domestic Partner <input type="checkbox"/> Retiree and Child <input type="checkbox"/> Retiree and Children <input type="checkbox"/> Retiree and Family		<input type="checkbox"/> New Enrollee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address or Phone <input type="checkbox"/> Add Dependent Coverage <input type="checkbox"/> (List names below) <input type="checkbox"/> Delete Dependent Coverage <input type="checkbox"/> Change Primary Care Physician <input type="checkbox"/> (List names below)			EFFECTIVE DATE
GROUP NAME SAN DIEGO PUBLIC EMPLOYEE BENEFIT ASSOCIATION		PLAN NUMBER 1006268-24	ARE YOU THE SURVIVING SPOUSE OF A CITY OF SAN DIEGO RETIREE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SOCIAL SECURITY NUMBER	NAME (Last, First, MI)	DATE OF BIRTH (MM/DD/YY)	PREFERRED LANGUAGE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME ADDRESS (Street and Number)		CITY	STATE	ZIP CODE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOW(ER)
HOME PHONE NO. ()		ALTERNATE PHONE NO. ()		E-MAIL	
PRIMARY CARE PHYSICIAN (Full Name—If left blank, plan will assign)			PCP OFFICE LOCATION		EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO (If "Yes", Complete the Following) <input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> 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. 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

I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. 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.