

OPEN ENROLLMENT APPLICATION 2008-2009 : ACTIVE CITY EMPLOYEE

You must complete this form and return it to HSS by April 30, 2008 if you are enrolling in a flexible spending account, changing your current medical and/or dental plan elections or adding or dropping dependents for coverage effective July 1, 2008. **Do not complete this form** if you are not enrolling in a flexible spending account, changing your current medical and/or dental elections and are not adding or dropping dependents for coverage effective July 1, 2008. Please refer to your Benefits Guide for information about available options and costs.

YOUR PERSONAL INFORMATION

Last Name	First Name	Middle Initial
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Street Address	Apt. #	City
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
	State	Zip Code
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Social Security Number 000-00-0000	Birth Date MM/DD/YYYY	Gender
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Telephone Number (000) 000-0000	Work Telephone Number (000) 000-0000	Email Address
(<input style="width: 95%;" type="text"/>) <input style="width: 95%;" type="text"/>	(<input style="width: 95%;" type="text"/>) <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

CHOOSE YOUR DENTAL PLAN

Delta Dental
 Pacific Union DMO
 DeltaCare USA DMO (formerly PMI Dental)
 No Dental Coverage

Note: If enrolling in Pacific Union or DeltaCare USA you must live in an area serviced by that DMO. Please refer to your Benefits Guide or contact the DMO to verify your eligibility.

CHOOSE YOUR MEDICAL PLAN

Blue Shield HMO
 Kaiser HMO
 PacifiCare HMO
 City Plan PPO
 No Medical Coverage

Primary Care Physician ID #
 Required for Blue Shield and PacifiCare only. Please refer to the HMO's website or the HMO Provider Directory to obtain a physician ID #.

Note: If enrolling in Blue Shield, Kaiser or PacifiCare you must live in an area serviced by that HMO. Please refer to your Benefits Guide or contact the HMO to verify your eligibility.

IF YOU WANT TO ADD OR DROP ANY DEPENDENTS FROM YOUR DENTAL AND/OR MEDICAL COVERAGE, PLEASE LIST BELOW.

If you don't indicate any changes, the dependents covered in 2008-2009 will remain the same as those you had covered in 2007-2008.

Last Name	First Name	Birth Date MM/DD/YYYY	M/F	Social Security # 000-00-0000	Relationship	Dental	Medical	Primary Physician ID # Blue Shield and PacifiCare only
						Add Drop	Add Drop	
						Add Drop	Add Drop	
						Add Drop	Add Drop	
						Add Drop	Add Drop	
						Add Drop	Add Drop	

DO YOU WANT A FLEXIBLE SPENDING ACCOUNT IN THE 2008-2009 PLAN YEAR?

Note: Flexible Spending Accounts require re-enrollment every Plan Year. If you do not re-enroll, your current contributions will terminate in June 2008.

Yes, I want a Dependent Care Flexible Spending Account. I want to contribute a total annual amount of \$ for the 2008-2009 Plan Year.
 (Annual amount divided by 24 equals your semi-monthly payroll deduction.) (Min \$120 - Max \$5000)

Yes, I want a Healthcare Flexible Spending Account. I want to contribute a total annual amount of \$ for the 2008-2009 Plan Year.
 (Annual amount divided by 24 equals your semi-monthly payroll deduction.) (Min \$120 - Max \$5000)

SIGNATURE

I certify that the information entered on this document is true and correct and I give the persons administering the plans in which I enroll and/or their agents permission to verify any and all information. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plans and HSS for any benefits paid for myself and/or my dependents if I or my dependents subsequently prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the falsification of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form. A copy of this form is as valid as the original.

Signature: _____ Date Signed: _____

Mail, fax or drop this form off in person to HSS, 1145 Market Street, 2nd Floor, San Francisco, CA 94103 Fax: (415) 554-1721 Phone: (415) 554-1750

TERMS AND CONDITIONS

Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:

- The Health Service System will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- You authorize the Health Service System to deduct in advance each applicable coverage period from wages due you any contributions required on your part to provide healthcare coverage for yourself and any eligible dependents listed on this form, and to remit such amounts to the benefit plans you have designated. This deduction may also include contribution amounts which are delinquent and due to the Health Service System.
- You agree to submit any contribution required on your part directly to the Health Service System during any unpaid leave of absence.
- Your participation in the Health Service System is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the Health Service System), as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during the Plan year (July 1-June 30) unless you have a qualifying family status change. Refer to your Benefits Guide for complete details.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to disciplinary action, dismissal and/or legal action.
- The terms and conditions of each medical/dental plan are contained in the individual plan documents available through each plan provider. If any difference exists between the plan documents and any descriptions, charts or summaries provided by the Health Service System, the terms and conditions of the plan documents will govern.
- THAT SOME OF THE HEALTH PLANS OFFERED BY THE HEALTH SERVICE SYSTEM CONTAIN A CLAUSE REQUIRING RESOLUTION OF MEDICAL MALPRACTICE AND OTHER DISPUTES THROUGH BINDING ARBITRATION. This clause expressly provides that when you select the applicable plan, you give up the right to a jury or court trial for resolution of these disputes. To determine whether the plan you have selected contains such a clause and, if so, what the exact terms and conditions of such clause are, consult the individual plan document available through applicable Plan Provider.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree to complete and submit to the plan provider any necessary forms, consents, releases, assignments, applications, questionnaires and other documents that the plan or HSS may reasonably request.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the Health Service System, you will promptly notify the Health Service System and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by HSS.
- For a complete description of eligibility requirements consult your Benefits Guide.