REMIF
REDWOOD EMPIRE MUNICIPAL INSURANCE FUND

GROUP ENROLLMENT/CHANGE FORM

P.O. BOX 45018, FRESNO, CA 93718-5018
(800) 442-7247 FAX (559) 499-2464

☐New Enrollment ☐Annual Enrollment
☐Name/Address ☐Change Enrollment
☐Change/Reinstatement ☐Decline Coverage
☐Retirement ☐Rehire ☐Termination

PART 1 EMPLOYEE INFORMATION

EMPLOYER	GROUP NUMBER	FOR EMPLOYER USE ONLY	FOR EMPLOYER USE ONLY
CITY OF ROHNERT PARK	R01	Loc. Code: Rhnrtpk Department Code:	Effective Date:

EMPLOYEE NAME (Last, First, MI) SS# ☐Medical ☐RP Dental ☐RP Vision

Last Name First Name MI

MAILING ADDRESS (Street, City, State, Zip) HOME PHONE ( ) BIRTHDATE: MO DAY YEAR

HIRE DATE

Full Time/Part Time (Circle one)
# of Hours Worked/Week : _____

☐MALE ☐FEMALE

☐SINGLE ☐MARRIED ☐DOMESTIC PARTNERSHIP
☐ DIVORCED ☐SEPARATED ☐WIDOWED

EMPLOYEE TERMINATION DATE REASON FOR TERMINATION

MEDICAL PLAN SELECTION: ☐EPO 250 ☐EPO 500 ☐PPO 500 ☐HSA 1400 ☐BlueCard 250 (Out of state Retiree only)
Kaiser PID 9853 ☐RP Kaiser 20 ☐RP Kaiser 40 ☐RP Kaiser HSA $1500 RP Kaiser $2500 ☐RP Kaiser Senior Advantage
☐ RP Sutter ML 27 $25 ☐RP Sutter ML 20 $500 ded ☐RP Sutter HSA $1500 ☐Alternate Benefit ☐United American

PART 2 DEPENDENT INFORMATION ONLY

DEPENDENT INFORMATION (List persons to be covered/terminated.): [1] Relationship Code (relationship to participant) SPO=Spouse **DP=**DOMESTIC PARTNER **CHI=Child**

Add/Drop (Circle)	Last Name	First Name	MI	Social Security ** Required **	Birth Date	Gender (Circle)	Relationship Code(1)	Disabled (Circle)	Plan Selection
A D						M F	Spouse/DP	Y N	☐Medical ☐Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐Dental ☐Vision
A D						M F	Child	Y N	☐Medical ☐Dental ☐Vision

IF ADDING OR DROPPING DEPENDENT, STATE REASON:

PART 3 OTHER INSURANCE INFORMATION

ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached.

Name of other policy holder	Birth Date	Social Security Number	[2] Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	[3] Benefit Types	[4] Policy Types	Coverage Date(s)
									Begin / / End / /

PERSONS COVERED UNDER ABOVE POLICY:

2 **Relationship Code** (specify relation to participant): SPO=Spouse OTH=Other
3 **Benefit Type(s)**: **M**=Medical D=Dental **V**=Vision
4 **Policy Type**(s): **IND**=Individual Policy **GRP**=Group Plan **HMO**=Health Maintenance Organization **MED**=Medicare

PART 4 COVERAGE DECLINATION

To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;

MEMBER DECLINING COVERAGE	COVERAGE DECLINED	REASON FOR DECLINING COVERAGE
Myself	☐Medical ☐Dental ☐Vision	☐ Covered by spouse's employer group plan
My Spouse/Domestic Partner	☐Medical ☐Dental ☐Vision	☐ Covered by Medicare
My Child(ren): _____	☐Medical ☐Dental ☐Vision	☐ Other: _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand if declining, I/we may have to wait until Open Enrollment to add the person(s) that is/are being declined. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If declining coverage for employee/dependent(s) please sign here. _____ Date _____

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Kaiser Arbitration

Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

Sutter Health Plus Arbitration

For employees selecting the Sutter Health Plus plan

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and *EOC*, upon completion and execution of this enrollment form.

Binding Arbitration:
Sutter Health Plus 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, Sutter Health Plus 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 *EOC*.

By my signature below, I agree to the above terms, if applicable.

PART 5	DECLARATION

I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.

_____

Employee Signature **Date**