

HSS ENROLLMENT APPLICATION 2010-2011 : SFCCD

You must submit a completed enrollment application and any required documentation within **30 days** of your initial benefits eligibility date or within **30 days** of a qualified change in family status. Please refer to your Benefits Guide or visit myhss.org for details. **Keep yellow copy for your records.**

You may be eligible for other benefits offered by SFCCD. For details contact SFCCD Benefits Unit - Certificated: (415) 487-2448; Classified: (415) 241-2310.

1 YOUR PERSONAL INFORMATION

Last Name		First Name		Initial
Street Address (no P.O. boxes)		City	State	Zip Code
Social Security Number	Birth Date MM/DD/YYYY	Gender M/F	Home / Cell Telephone Number	
eMail Address			Work Telephone Number	

HSS cannot process mailing address changes for active SFCCD employees. You must contact your department personnel supervisor to update the home address on file with your employer.

2 CHOOSE YOUR MEDICAL PLAN

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

*To enroll in these plans you must live in an area serviced by the HMO. Please refer to your HSS Benefits Guide or contact the HMO to verify your eligibility.

3 TO ADD OR DROP ANY DEPENDENTS FROM YOUR MEDICAL COVERAGE, PLEASE LIST BELOW.

You must submit required eligibility documentation for the initial enrollment of any dependents. See the reverse side of this form for details.

Medical	Last Name	First Name	MM/DD/YYYY Birth Date	M/F	Social Security Number	Relationship
Add <input type="checkbox"/> Drop <input type="checkbox"/>						
Add <input type="checkbox"/> Drop <input type="checkbox"/>						
Add <input type="checkbox"/> Drop <input type="checkbox"/>						
Add <input type="checkbox"/> Drop <input type="checkbox"/>						
Add <input type="checkbox"/> Drop <input type="checkbox"/>						
Add <input type="checkbox"/> Drop <input type="checkbox"/>						

4 SIGNATURE & CERTIFICATION

Under penalty of perjury I certify that the information entered on this document is true and correct. I give the persons administering the plans in which I enroll and/or their agents permission to verify any and all information. **It is my responsibility to notify the Health Service System when a dependent becomes ineligible. I agree to assume full financial responsibility** for all expenses and to reimburse and indemnify the plans and the Health Service System for any benefits paid for myself and/or my dependents if I or my dependents 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: _____

WHERE TO SUBMIT THIS APPLICATION AND REQUIRED DOCUMENTATION

Mail, fax or bring to SFCCD, HR Dept, Benefits Unit, 33 Gough St, SF, CA 94103

Fax: (415) 241-2347

Phone: (415) 241-2246

Questions about health benefits eligibility?

Call SFCCD (415) 241-2246 Online: www.ccsf.edu/hr

Questions about medical benefits enrollment?

Call HSS (415) 554-1750 Online: www.myhss.org

ENROLLMENT APPLICATION: 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 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 authorize the Health Service System to deduct in advance of 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 reimbursement of premium and claims costs on a retroactive basis, disciplinary action, dismissal and/or legal action.
- The terms and conditions of each medical 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 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 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.
- The following documentation is required, in addition to a completed HSS Health Benefits Enrollment Application, for any eligible individual's enrollment. HSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTATION

	EVIDENCE OF HIRE	BENEFIT AUTH. FORM	MARRIAGE CERTIFICATE	DOMESTIC PARTNER REG.	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	COURT ORDER	INCOME TAX RETURN	MEDICAL EVIDENCE	SOCIAL SECURITY #
Employee: Permanent/Provisional	■									■
Employee: Temporary/Exempt		■								■
Spouse			■							■
Domestic Partner				■						■
Child: Natural					■					■
Child: Step-child			■	■	■			■		■
Child: Domestic Partner				■	■					■
Child: Adopted						■				■
Child: Legal Guardianship							■			■
Child: IRS Exemption					■			■		■
Child: Court Ordered							■			■
Child: Disabled									■	■

If you have questions about eligibility or required documentation contact HSS Member Services at (415) 554-1750.