LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
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2023 Medical/Dental Plan Family Account Change Form

USE THIS FORM TO ADD OR DELETE DEPENDENTS

1. SUBSCRIBER INFORMATION

Last Name	First Name, Middle Initial	Birth Date	Social Security Number	Medicare Beneficiary Identifier	Daytime Number

2. MEDICAL/DENTAL PLANS

Anthem Blue Cross ☐ HMO (California only) ☐ PPO ☐ Medicare Preferred PPO Plan (Medicare Advantage with Rx)	**SCAN Health Plan** ☐ California	**UnitedHealthcare Medicare Advantage HMO** ☐ California ☐ Arizona ☐ Nevada	**Dual Care HMO Plans** **Anthem Blue Cross HMO &** ☐ SCAN Health Plan ☐ UnitedHealthcare Medicare Advantage HMO (Calif. only)

☐ **Delta Dental PPO℠** - 17228 10001	☐ **DeltaCare® USA HMO -** 76992 for ___CA 00001 or___ Parts of NV only 00003

Kaiser Permanente (California only) ☐ HMO ☐ Senior Advantage	**Kaiser Permanente** Purchaser ID number with Enrollment Unit: 225576-0 (SoC) / 605559-0 (NoC)	Enrollment reason: ☐ Retirement ☐ Open Enrollment ☐ Loss of Coverage ☐ Other_____	Event Date _____

3. ADD DEPENDENTS: List Eligible Dependents to be Enrolled in the Medical/Dental Plan

Last Name, First Name, Middle Initial	Social Security Number	Medicare Beneficiary Identifier	Gender	Relationship	Birth Date	Medical/ Dental Plan	Effective Date
			☐ M ☐ F				
			☐ M ☐ F				

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers, DeltaCare® USA HMO Facility # Participating Dentist

4. DELETE DEPENDENTS: List Dependents to be Deleted in the Medical/Dental Plan

Last Name, First Name, Middle Initial	Social Security Number	Medicare Beneficiary Identifier	Gender	Relationship	Effective Date	Medical/ Dental Plan	Reason
			☐ M ☐ F				
			☐ M ☐ F				

OVER - See Page 2 for Member signatures

DELETED DEPENDENTS ADDRESS: _____

_____

5. MEMBER AUTHORIZATION

I understand this election will remain in effect as long as I remain eligible, or until I make another election during the Open Enrollment period. I hereby authorize: 1) LACERS to deduct from my retirement allowance my share of the monthly premiums as may be established from time to time in the service agreement; and 2) any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay claims under the plan selected. I want to enroll myself and those dependents listed above in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents and that the benefits or services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) may be subject to binding arbitration. I understand that LACERS will select the earliest coverage date possible for me unless I notify them otherwise.

Member's Signature **Date**

Kaiser Foundation Health Plan 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 Kaiser Permanente Plan **Date**

FOR OFFICE USE ONLY			
INITIALS	YEARS OF SERVICE	MEDICAL SUB/PART	EFFECTIVE DATE

MAIL TO: LACERS, Attn: Health Benefits Administration
PO Box 512218
Los Angeles, CA 90051-0218

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.