SBCERS THE SUPERIOR COURT OF CALIFORNIA COUNTY OF SANTA BARBARA

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Blue Shield Subscriber Enrollment / Change Form

☐ New Enrollment ☐ Termination of Coverage ☐ Add Medicare A & B
☐ Open Enrollment ☐ Delete Dependent ☐ COBRA Election
☐ Address/Name Change ☐ Add Dependent ☐ Extended COBRA Election

Effective Date: _____

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			$

Notes: _____

SELECT MEDICAL AND PRESCRIPTION PLAN AND TYPE OF COVERAGE:

Medical and Prescription Plan	Type of Coverage
☐ **EPO Low** Option Medical with Express Scripts Regular Prescription Drug Plan	☐ RET only
☐ **EPO Low** Option Medical with Express Scripts ***Medicare*** Prescription Drug Plan*	☐ RET + 1 Dependent
☐ **HDHP** with Blue Shield Prescription Plan	☐ Retiree + Family

**Selection of Medicare Prescription Drug Plan requires that you supply Medicare HICN and effective dates of Parts A & B for all Medicare enrolled participants where indicated below. NOTE: All Medicare-enrolled participants must be enrolled in the same prescription plan.*

RETIREE INFORMATION

Last Name	First Name		M.I.	☐ Male ☐ Female
Social Security Number	Birth Date (mm/dd/yyyy)	Home Phone:	Work Phone:	
Residence Street Address	City		State	Zip Code
Mailing Street Address	City		State	Zip Code
Marital Status: ☐ Single ☐ Married ☐ Registered Domestic Partner (RDP) ☐ Legally Separated ☐ Divorced ☐ Widowed				
E-Mail Address:	*Medicare: ☐ Part A, Effective _____ ☐ Part B, Effective _____		*Medicare Claim / HICN	

DEPENDENT INFORMATION (List all eligible family members to be enrolled. Attach additional sheets if necessary.)

☐ Spouse ☐ RDP	Last Name	First Name	M.I.	☐ Male ☐ Female
Residence Street Address ☐ Check here if same as Retiree		City	State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	*Medicare: ☐ Part A, Effective _____ ☐ Part B, Effective _____	*Medicare Claim / HICN	
☐ Son ☐ Daughter	Last Name	First Name	M.I.	☐ Overage Dependent ☐ Disabled ☐ Over 50% IRS Support
Residence Street Address ☐ Check here if same as Retiree		City	State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	*Medicare: ☐ Part A, Effective _____ ☐ Part B, Effective _____	*Medicare Claim / HICN	

Signature is required on page 2

Retiree Name: _____

Initial either acceptance or declination of coverage:

☐ **ACCEPTANCE OF COVERAGE** ☐ **DECLINATION OF COVERAGE**

Complete the following section if coverage is to be declined by you or your eligible dependents.

I decline Medical coverage for *(check all that apply)***:**

☐ Self ☐ Spouse/RDP ☐ Child(ren)

☐ Spouse/RDP and Child(ren)

☐ The Following Dependents Only (List Name & SSN)

_____ _____

_____ _____

_____ _____

Reason for Declination

☐ **Other Coverage**
Insurance Carrier Name
_____

☐ Other reasons
_____

The available coverages have been explained to me. I have been given the chance to apply for the available coverages.

Declination: If I have decided *not* to enroll myself and/or my dependent(s), by signing below, I acknowledge that by declining coverage my dependents and I may have to wait until the next Open Enrollment period or qualifying event to be enrolled.

Authorization to obtain or release medical information explanation: *The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. Seq. of the California Civil Code. Your cooperation is being requested.*

Enrollment and Authorization: If I have decided *to enroll* myself and/or my dependent(s), by signing below, I acknowledge that by enrolling I am I hereby authorizing my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim.

_____ _____

Retiree Signature *(for Enrollment or Declination)* **Date**

Return completed forms to your Benefits Specialist:

☐ SBCERS
130 Robin Hill Rd, Suite 100
Goleta, CA 93117

☐ SBCERS
2236 South Broadway Suite D
Santa Maria, CA 93454

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Completed by: _____ Date: _____