VOLUNTARY IDENTIFICATION OF RACE AND ETHNIC ORIGIN FOR APPLICANT WITH OR WITHOUT DEPENDENT(S)

SFHSS is aligning with leading health authorities to ensure that equity is engrained within the fabric of our mission, vision, values, and strategic goals. To reduce disparities, we must begin with accurate data collection. We believe the collection of this optional data will meaningfully advance equity mandates. Plan enrollment will not be affected if you choose not to provide this information.

APPLICANT

Last Name	First	Middle	DSW

What is your race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ I choose not to answer

Are you of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ I choose not to answer

DEPENDENT #1

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ I choose not to answer

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ I choose not to answer

DEPENDENT #2

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ I choose not to answer

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ I choose not to answer

VOLUNTARY IDENTIFICATION OF RACE AND ETHNIC ORIGIN FOR APPLICANT WITH OR WITHOUT DEPENDENT(S)

DEPENDENT #3

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

DEPENDENT #4

Last Name	First	Middle	Relationship

What are their race?

- ❑ American Indian or Alaska
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Chinese
- ❑ Filipino
- ❑ Guamanian or Chamorro
- ❑ Japanese
- ❑ Korean
- ❑ Native Hawaiian
- ❑ Other Asian
- ❑ Other Pacific Islander
- ❑ Samoan
- ❑ Vietnamese
- ❑ White

❑ **I choose not to answer**

Are they of a Hispanic, Latino/a, or Spanish Origin?

- ❑ No
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Another Hispanic, Latino/a or Spanish Origin

❑ **I choose not to answer**

PRIVACY NOTICE ON VOLUNTARY INFORMATION COLLECTION

I, hereby, understand that completion of this form is not required and is therefore completely voluntary. The San Francisco Health Service System (SFHSS) is committed to diversity, equity, and inclusion and uses provided demographic information to help ensure equity and reduce disparities in healthcare and health outcomes.

SFHSS is committed to maintaining the privacy of your personal information. You have a right to review, change, or correct any demographic information that you gave to SFHSS. Please contact Member Services to review, change or correct any personal information that you have provided SFHSS, please visit *https://sfhss.org/contact-us*.

For more information on the Citywide Race/Ethnicity Data Standard, please visit the Office of Racial Equity (ORE) webpage at *https://www.racialequitysf.org/race-ethnicity-data-standard*, and for more information on the SFHSS Strategic Plan, please visit *https://sfhss.org/sfhss-strategic-plan-2023-2025*.

Signed:_____ Date: _____

SFHSS USE ONLY Enrolled by: _____ Date: _____ Processed by: _____ Date: _____

HEALTH BENEFITS ENROLLMENT APPLICATION: RETIREE OR DEPENDENT(S) WITH MEDICARE FOR JANUARY–DECEMBER 2024 YEAR PLAN

You must submit a completed enrollment application and required eligibility documents to the San Francisco Health Service System (SFHSS) **within 30 days** of your initial benefits eligibility date, qualifying life event (QLE), or within the Open Enrollment (OE) period. Refer to your Benefits Guide or visit **sfhss.org** for more details.

1 APPLICATION TYPE (Select One)

☐ Retirement ☐ Open Enrollment

QUALIFYING LIFE EVENT ☐ Birth/Adoption ☐ Marriage/Partnership ☐ Separation/Dissolution/Divorce ☐ Ineligible ☐ Other Coverage ☐ Other _____

2 YOUR PERSONAL INFORMATION

Last Name	First Name	Initial	DSW/Employee ID Number

Street Address (no P.O. boxes)	City	State	Zip Code

Social Security Number (SSN)	Birth Date MM/DD/YYYY	Gender M/F	Home Telephone Number

Email Address	Cell Telephone Number

3 YOUR MEDICARE INFORMATION

Complete this section if you are eligible for Medicare. If you are not yet eligible for Medicare, leave this section blank.

Medicare Claim Number (as it appears on card)	Medicare Part A Effective Date (MM/DD/YYYY)	Medicare Part B Effective Date (MM/DD/YYYY)

4 MEDICAL PLAN (includes Basic VSP)[2,5]

☐ UnitedHealthcare Medicare Advantage PPO
Coverage for Individual Not Eligible for Medicare[1,4]:
- ☐ UHC Select Network Plan EPO
- ☐ UHC Doctors Plan EPO
- ☐ UnitedHealthcare Non-Medicare PPO

☐ Kaiser Permanente Senior Advantage HMO[1]
☐ Waived Medical Coverage

5 DENTAL PLAN[5]

☐ Delta Dental PPO
☐ UnitedHealthcare Dental DHMO[1]
☐ Deltacare USA DHMO[1]
☐ Waived Dental Coverage

6 VISION PLANS

☐ VSP Basic Plan[2] ☐ VSP Premier Plan[3]

If you are currently enrolled in the VSP Premier Plan, you and your dependents will automatically be re-enrolled in the VSP Premier Plan next year. If you do not wish to re-enroll in VSP Premier, check the VSP Basic Plan box.

[1]To enroll in an HMO/DHMO Plan, you must live in an area serviced by the HMO/DHMO. [2]Enrollment in any medical plan automatically includes enrollment in the VSP Basic Vision Plan. [3]VSP Premier Plan is an additional cost. To enroll in this plan, you and your dependents must be enrolled in a medical plan and all dependents must also enroll in the VSP Premier Plan. [4] Applicable only if UnitedHealthcare Medicare Advantage PPO has been selected for the Medicare eligible individual. [5]For new Retirees who wish to enroll in COBRA, follow the instructions on the COBRA application that you receive from P&A Group. SFHSS does not process COBRA enrollment.

7 TO ADD OR DROP DEPENDENTS FROM YOUR MEDICAL AND/OR DENTAL 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 more details.

Medical Add ☐ Drop ☐	Dental Add ☐ Drop ☐	Last Name	First Name	Birth Date	Gender M/F	SSN	Relationship

8 DEPENDENT MEDICARE INFORMATION

List all Medicare-eligible dependents, attach additional sheet if necessary. If dependents are not Medicare-eligible, leave blank.

Last Name	First Name	Medicare Claim Number (as it appears on Medicare card)	Medicare Part A (Effective Date MM/DD/YYYY)	Medicare Part B (Effective Date MM/DD/YYYY)

9 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.

10 SALARY REDUCTION AGREEMENT & SIGNATURE

Under penalty of perjury I certify that the information entered on this document is true and correct. I hereby authorize and direct the San Francisco Health Service System (SFHSS) to reduce my pension in the amount necessary to pay for coverage elected in this document for which I am eligible for. I further understand that should my pension not be enough to pay for my elected coverage, I will pay the SFHSS directly to retain such coverage. **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:

Mail or drop off this form in person to: SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103 • SFHSS Member Services Phone: (628) 652-4700.
Fax forms to: (628) 652-4701 • **Please do not fax the same application multiple times.** • **Keep a copy of this form for your records.**

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

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

- The San Francisco Health Service System (SFHSS) 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 SFHSS may reasonably request.
- **You understand that your elections will remain in effect and cannot be revoked or changed until the next Open Enrollment period unless the revocation and new election are on account of and consistent with a change in family status (e.g., marriage, divorce, death of spouse or child, birth or adoption of a child, termination of employment of spouse, etc.) as listed in the Employers Plan Documents.**
- You agree to submit any contribution required on your part directly to SFHSS during any unpaid leave of absence.
- Your participation in the SFHSS is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of SFHSS as the same may be amended, modified or supplemented from time to time).
- Any misrepresentation 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/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 SFHSS, the terms and conditions of the plan documents will govern.
- You understand that **some of the health plans offered by SFHSS 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 that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through SFHSS, you will promptly notify SFHSS and submit all requested documentation. Eligibility of dependents may be audited at any time and require submission of documentation that substantiates and confirms that the dependent's relationship with the employee or retiree is current.
- All healthcare services provided or benefits paid on behalf of any ineligible employee, retiree, or dependent are subject to collection by the health plan involved or by SFHSS.
- The following eligibility documents are required, in addition to a completed Health Benefits Enrollment Application, for any eligible individual's enrollment. SFHSS may request documentation of eligibility at any time.

REQUIRED ELIGIBILITY DOCUMENTS

	CERTIFIED MARRIAGE CERTIFICATE	DOMESTIC PARTNER CERTIFICATE	BIRTH CERTIFICATE	ADOPTION CERTIFICATE	PROOF OF PLACEMENT	COURT ORDER OR DECREE	SOCIAL SECURITY #
Employee: Permanent/Provisional							■
Employee: Temporary/Exempt							■
Spouse	■						■
Domestic Partner		■					■
Child: Natural			■				■
Step Child: Spouse	■		■				■
Step Child: Domestic Partner		■	■				■
Child: Adopted				■			■
Child: Placed for Adoption					■		■
Child: Legal Guardianship (Up to Age 19)						■	■
Child: Court Ordered (Up to Age 19)						■	■
Adult Child: Disabled			■				■

Proof of Medicare enrollment is also required for a registered domestic partner who is Medicare eligible due to age or disability.
Please visit sfhss.org for full eligibility requirements.