SHARP Health Plan | SAN DIEGO PEBA

Non-Medicare

Enrollment Application

Eligibility requirements for non-Medicare retirees

- ☑ Be a City of San Diego retiree or a spouse and / or dependent of that person.
- ☑ Live in the Sharp Health Plan service area (San Diego and southern Riverside counties).

Please Note: Membership in MEA, REA, RFPA or SDPEBA is **not** required.

Instructions

Answer all questions and fill in check boxes with an X.

- Sign the form on page 3 and date it. Be sure you have read all the pages before you sign.

Submit

Please submit the finished form by mail, in person, fax or email:

By mail or in person:
San Diego Public Employee Benefit Association (SDPEBA)
9620 Chesapeake Dr., Suite 104
San Diego, 92123

By fax:
(619) 431-3078

By email:
support@sdpeba.org

If you need assistance, we're here to help. You can call SDPEBA at 1-888-315-8027.

Employer use only

Group name:	Group number:	Effective date (MM/DD/YY):
San Diego Public Employee Benefit Association (SDPEBA)	1006268	/ /

Plan selection*

☐ Classic Plan (Non-Medicare) 20/20/100 ☐ Select Plan (Non-Medicare) 20/30/500

Indicate coverage below* (check one coverage level)

☐ Subscriber ☐ Subscriber + 1 ☐ Subscriber + Family

Reason for this application

☐ New enrollee
☐ Open enrollment
☐ Name change (list change below)
☐ Address or phone change (list change below)
☐ Add dependent coverage (list below)
☐ Remove dependent coverage (list below)
☐ Primary care physician change (list change below)
☐ Termination (coverage end date MM/DD/YY)
_____/_____/_____

Employee information

Are you a City of San Diego retiree? ☐ Yes ☐ No If "No" please complete →	Retiree name (last, first, middle initial):

Are you the surviving spouse of the City of San Diego retiree? ☐ Yes ☐ No

*Please note, if your dependent is Medicare-eligible, a different form is required.

Employee information, continued

First name:	Last name:	Middle initial:

Social Security number: – –	Birth date: MM/DD/YY / /	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Registered domestic partnership (filed with CA Sec. of State) ☐ Non-registered domestic partnership (requires SDPEBA approval)

Sex assigned at birth: ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose	Gender identity: ☐ Man ☐ Woman ☐ Transgender male/trans man/ female-to-male (FTM). ☐ Transgender female/trans woman/male-to-female (MTF). ☐ Non-Binary, neither exclusively male nor female. ☐ Additional gender category or other, please specify: _____ ☐ Choose not to disclose.	Preferred gender pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Something else, please specify: _____ ☐ Choose not to disclose.	Sexual orientation ☐ Lesbian or gay or homosexual. ☐ Straight or heterosexual. ☐ Bisexual ☐ Something else, please specify: _____ ☐ Don't know. ☐ Choose not to disclose.

Cell phone number: ( )	Home phone number: ( )	Other phone number: ( )

Email address:	Preferred language:

Home address (P.O. Box is not allowed):		

City:	State:	ZIP code:

Primary care physician information (if left blank, Sharp Health Plan will assign)

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findadoctor** or call 1-888-840-4747, Monday to Friday, 8 am to 6 pm.

Primary care physician name:	Provider NPI:	Are you an existing patient with this doctor? ☐ Yes ☐ No

Dependent information (Please note, if your dependent is Medicare-eligible, a different form is required.)

Last name, first name, M.I.	Social Security	Date of birth MM/DD/YY	Sex	Primary care physician (if left blank, Sharp Health Plan will assign)	Existing patient?
Spouse: Date of marriage:		/ /	☐ M ☐ F		☐ Yes ☐ No
Domestic partner: Affidavit submitted? ☐ Yes ☐ No		/ /	☐ M ☐ F		☐ Yes ☐ No
Child:		/ /	☐ M ☐ F		☐ Yes ☐ No
Child:		/ /	☐ M ☐ F		☐ Yes ☐ No
Child:		/ /	☐ M ☐ F		☐ Yes ☐ No
Child:		/ /	☐ M ☐ F		☐ Yes ☐ No

Other medical coverage

Do you or your dependents intend to continue other medical or Medicare coverage? ☐ Yes ☐ No
If "Yes" complete the following: ☐ Self ☐ Spouse ☐ Dependent

Name of insured:	Dependents enrolled with other medical coverage:	
Name of other insurance company:	Group number / Policy number:	Coverage start date: MM/DD/YY / /

Disclosures and signatures

Please read the following carefully before signing.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application.

The undersigned expressly consents and agrees that Sharp Health Plan, its business associates, and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, at any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded messages or live operator calls. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care or coverage in any way. Visit **www.sharphealthplan.com/terms** for complete Terms of Use.

Arbitration Agreement

I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

Acknowledgment

I authorize SDCERS and SDPEBA to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at SDCERS and SDPEBA's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that SDCERS and SDPEBA's application will determine coverage and that there is no coverage unless and until this application and an application made by SDCERS and SDPEBA have been accepted and approved by Sharp Health Plan.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

Authorization to obtain or release medical information

Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act, Section 56 et seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp Health Plan, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation, or evaluation of any application or a claim. I authorize Sharp Health Plan, or agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for 30 months to permit evaluation of this application, or for the term of coverage to allow the processing of claims. A photocopy of this authorization shall be as valid as the original.

Misrepresentation

I have read and understood the provisions outlined on the front and back of this form. All information I have provided on this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. I understand that I am entitled to a copy of this signed (Non-Medicare) Enrollment Application and Authorization.

Employee signature:	Date: MM/DD/YY
X	/ /

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711) Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English:
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese):
注意 ： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。。

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

(Farsi): فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

(Arabic): العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).