Qualifying Life Event Change Form

2019 Health and Dental Plan

Sworn LAPD & LAFD

City of Los Angeles • Personnel Department • Employee Benefits Division • **213-978-1655**

KEEPING LAwell
City of Los Angeles Employee Benefits

When you experience a qualifying life event, you have **30 days** from the date of the event to notify and make changes to your benefits by contacting Maria Lopez at 213-978-1584. You will have **60 days** from the date of contact to submit documentation to the Employee Benefits Division. This includes, but is not limited to documents such as birth certificates, marriage certificates, divorce decrees, court orders, full-time student certificates, Cash-In-Lieu Affidavits, Domestic Partnership Affidavits, etc. Failure to submit documentation within **60 days** will cancel your changes on day 61. New dependents will not be offered COBRA. You will be responsible for any rejected claims that are incurred as a result of the cancellation, regardless of when you are notified of the cancellation.

SECTION A

EMPLOYEE/SUBSCRIBER INFORMATION

Name (Last, First, Middle Initial)	Employee ID or Social Security Number	Sex ○ Female ○ Male

Address	City	State	Zip Code

Phone Number	Email Address

SECTION B

WHAT QUALIFYING LIFE EVENT DID YOU/YOUR DEPENDENT EXPERIENCE?

- ○ Marriage
- ○ Divorce
- ○ Death
- ○ Birth/Adoption
- ○ Moved Outside of Service Area
- ○ Begin Domestic Partnership
- ○ End Domestic Partnership
- ○ Significant change in spouse/ domestic partner's employer coverage
- ○ Gain of Coverage
- ○ Loss of Coverage
- ○ Court Order
- ○ Child no longer eligible

SECTION C

DEPENDENT INFORMATION (Add or Delete Coverage)

Name	Sex		SSN	Relationship	Birth Date	Coverage		Primary Care IDs	
	Female	Male				Add	Delete	Physician[1]	Dentist[2]
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		
	○	○				○ Medical ○ Dental	○ Medical ○ Dental		

[1] Fill out the Primary Care Physician ID only if you selected the Anthem Narrow Network or Anthem Vivity plan. To find the ID of your doctor/medical group, please visit **anthem.com/ca/cityofla** or call the Anthem Blue Cross Member Services Concierge at **844-497-5954** Monday through Friday, 8:00 a.m. to 8:00 p.m. and use the "Find a Provider" option.

[2] Fill out the Primary Care Dentist ID only if you selected the DeltaCare USA DHMO plan. To find the ID of your dentist, please visit **deltadentalins.com** and use the "Find a Dentist" option.

SECTION D: As a result of my qualifying life event, I would like to…

SWITCH coverage and join the following plan(s)	CANCEL my enrollment in the following plan(s)	MAKE NO CHANGE
○ Kaiser Permanente HMO (17) ○ Anthem Narrow Network (Select HMO) (16) ○ Anthem Vivity (LA & Orange Counties) (14) ○ Anthem PPO (13)	○ Kaiser Permanente HMO (17) ○ Anthem Narrow Network (Select HMO) (16) ○ Anthem PPO (13) ○ Anthem Vivity (LA & Orange Counties) (14)	
○ DeltaCare USA DHMO (19) ○ Delta Dental PPO (18)	○ DeltaCare USA DHMO (19) ○ Delta Dental PPO (18)	
○ Cash-In-Lieu (CL) can also be elected using the online site	○ Cash-In-Lieu (CL)	○ No Change

SECTION E: If ending coverage for a family member, please fill out Section E.

For the purpose of notifying any removed dependents of their COBRA rights, provide their mailing address
Mailing Address

All required documentation, including this form, must be submitted to:

City of Los Angeles, Personnel Department, Employee Benefits Division
200 North Spring Street, City Hall #867, Los Angeles, CA 90012

You may also fax the documents to 213-978-1623 or email them to per.empbenefits@lacity.org
(E-mail is preferred so that you can receive an acknowledgement of receipt.)

Contact Maria Lopez at 213-978-1584 if you have questions.

SECTION F

I understand this election will remain in effect so long as I remain eligible or until I make another election during a valid enrollment period or qualifying life event. I hereby authorize 1) the City of Los Angeles' Office of the Controller to deduct my share of monthly premiums from my salary as a result of this election; and 2) my medical and/or dental insurance provider to pay claims under the plan selected. By signing this form, I indicate my interest in enrolling myself and any listed dependents into the City's LAwell Plan and I understand that it is my responsibility to report any change in the eligibility of my dependents. I also understand that I must abide by the provisions of the health plan in which I enroll, and that any dispute between any member and their health plan (including its agents, staff physicians, employees, and providers) is subject to binding arbitration.

BINDING ARBITRATION

Anthem Narrow HMO: Select, Anthem Regional HMO: Vivity, Anthem PPO Prudent Buyer, and Kaiser Permanente HMO health plans use binding arbitration to settle disputes, including benefit claims, medical malpractice claims and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

By enrolling in any LAwell health plan, you agree to give up your constitutional right to have any dispute decided in a court of law before a jury, and instead, are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between the individuals seeking services under the plan, whether referred to as a member, subscriber, dependent, enrollee, or otherwise (whether a minor or adult), or the heirs−at−law or personal representatives of any such individual(s), as the case may be; and the health plan (including any of their agents, successors− or predecessors−in−interest, employees, or providers).

Employee Signature **Date**