

Non-Medicare

Enrollment Application

Eligibility requirements for non-Medicare retirees

- ☒ Be a city of San Diego retiree or a spouse 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, by fax or by email:

By mail or in person:

San Diego Public Employee Benefit Association (SDPEBA)
9150 Chesapeake Dr. #220
San Diego, CA 92123

By fax:

1-619-431-3078

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:

San Diego Public Employee Benefit Association (SDPEBA)

Group number:

1006268

Effective date (MM/DD/YY):

/ /

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

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 the California Secretary 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) ☐ Nonbinary, neither exclusively male nor female ☐ Additional gender category or other, please specify: _____ ☐ Choose not to disclose	Pronouns: ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Something else, please specify: _____ ☐ Choose not to disclose	Sexual orientation: ☐ Lesbian, 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 a.m. to 6 p.m.				
Primary care physician name:	Provider NPI:	Are you an existing patient with this doctor? ☐ Yes ☐ No		

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

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

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, to 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 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 San Diego City Employees' Retirement System (SDCERS) and San Diego Public Employee Benefit Association (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's or 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's 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:

X

Date: MM/DD/YY

/ /

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. A copy of the Nondiscrimination Notice can also be accessed at sharphealthplan.com/members/notices-and-disclosures.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 711).

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 and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572
- Email: shpcompliance@sharp.com

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.dmhca.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، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید
1-800-359-2002 (TTY:711) با. باشد می فراهم.

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。

:عبرعلا (Arabic)

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/TDD: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ ល គឺអាចមានសំរាប់អ្នក។
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। कॉल करें।

ภาษาไทย (Thai):

เรียน: ถ้านคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).