Medical/Dental Plan Family Account Change Form

USE THIS FORM TO ADD OR DELETE DEPENDENTS - PLEASE PRINT

1. SUBSCRIBER INFORMATION

Last Name	First Name, Middle Initial	Birth Date	Daytime Phone Number

2. MEDICAL/DENTAL PLANS

Anthem Blue Cross	Kaiser Permanente (California Only)	SCAN	UnitedHealthcare HMO	Dual Care HMO Plans
☐ HMO (California only) ☐ PPO ☐ Medicare Advantage LPPO	☐ HMO ☐ Senior Advantage	☐ California ☐ Arizona	☐ California ☐ Arizona ☐ Nevada	**Anthem Blue Cross HMO &** ☐ **SCAN** ☐ **UnitedHealthcare HMO** (California Only)

☐ **MetLife Dental PPO** ☐ **SafeGuard Dental HMO** (California & parts of Nevada)

3. ADD DEPENDENTS: List Eligible Dependents to Be Enrolled In the Medical/Dental Plan

Last Name, First, MI	Social Security Number	Gender	Relationship	Birth Date (mm/dd/yy)	**Primary Care Physician** Anthem Blue Cross HMO, SCAN, UnitedHealthcare HMO subscribers **SafeGuard Facility #** Participating Dentist
		☐ M ☐ F			
		☐ M ☐ F			

4. DELETE DEPENDENTS: List Dependents to Be Deleted In the Medical/Dental Plan

Last Name, First, MI	Social Security Number	Gender	Relationship	Birth Date (mm/dd/yy)	Medical/Dental Plan	Effective Date
		☐ M ☐ F				
Address:					Reason:	
		☐ M ☐ F				
Address:					Reason:	

5. MEMBER AUTHORIZATION

I understand this election will remain in effect as long as I remain eligible, or until I make another election during the Open Enrollment period. I hereby authorize: 1) LACERS to deduct from my retirement allowance my share of the monthly premiums as may be established from time to time in the service agreement; and 2) any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay claims under the plan selected. I want to enroll myself and those dependents listed above in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents and that the benefits or services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) may be subject to binding arbitration. I understand that LACERS will select the earliest coverage date possible for me unless I notify them otherwise.

MEMBER'S SIGNATURE **DATE SIGNED**

FOR OFFICE USE ONLY			
INITIALS	YEARS OF SERVICE	MED/DENTAL SUB/PART	EFFECTIVE DATE

OVER

LACERS
LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM

6. STUDENT CERTIFICATION

REQUIREMENTS FOR DEPENDENT STUDENT COVERAGE: Full-time student in an accredited institution, dependent on subscriber for financial support, unmarried and under the age of 25. Note: You must attach proof of current enrollment.

Dependent's Full Name:	**Birth Date** (mm/dd/yy):
School Name:	Student ID Number:
School Address (Street, City, State, Zip Code):	Number of Units Carried:
Dependent's Full Name:	**Birth Date** (mm/dd/yy):
School Name:	Student ID Number:
School Address (Street, City, State, Zip Code):	Number of Units Carried:

I certify that the dependents shown above meet all of the requirements for coverage in my LACER health plan as a full time student. I understand that coverage for the above-listed dependents will terminate on the first day of the month following the date that any one of the above requirements is no longer in effect.

MEMBER'S SIGNATURE **DATE SIGNED**

MAIL TO: LACERS, Attn: Health Benefits Administration, 360 E. Second St., 2nd Fl., Los Angeles, CA 90012-4207