LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
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(800) 779-8328 | RTT (888) 349-3996 | Fax (213) 473-7297

2025 Medical/Dental Plan Family Account Change Form

USE THIS FORM TO ADD OR DELETE DEPENDENTS

1. SUBSCRIBER INFORMATION

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

Medicare Beneficiary Identifier, if applicable

2. MEDICAL/DENTAL PLANS

Medical plans: ***Additional form(s) required if you and/or your dependent(s) has Medicare.***

Anthem Blue Cross
- ☐ HMO (California only*)
- ☐ PPO
- ☐ Medicare Preferred PPO Plan (Medicare Advantage with Rx)
- ☐ Medicare Supplement Plan (Medicare Supplement with Rx)

SCAN Health Plan
- ☐ California*

UnitedHealthcare Medicare Advantage HMO
- ☐ California*
- ☐ Arizona*
- ☐ Nevada*

Dual Care HMO Plans (California only*)
- ☐ Anthem Blue Cross HMO & SCAN Health Plan
- ☐ Anthem Blue Cross HMO & UnitedHealthcare Medicare Advantage HMO

Kaiser Permanente (California only*)
- ☐ HMO
- ☐ Senior Advantage

Kaiser Permanente Purchaser ID number with Enrollment Unit:
(SoCal) 225576-0 / (NoCal) 605559-0

** Available only within authorized zip code service areas.*

Dental plans	Enrollment reason	Event Date
☐ **Delta Dental PPO℠** – 17228 10001 ☐ **DeltaCare® USA HMO** – 76992 for ☐ CA 00001 **or** ☐ Parts of NV only 00003	☐ Retirement ☐ Open Enrollment ☐ Loss of Coverage ☐ Other: _____	

3a. ADDING DEPENDENTS: Eligible Dependents to be Enrolled in the Medical/Dental Plan

Last Name, First Name, Middle Initial	Social Security Number	Medicare Beneficiary Identifier	Gender	Relationship	Birth Date	Medical and/or Dental	Effective Date
			☐ M ☐ F				
			☐ M ☐ F				

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers, DeltaCare® USA HMO Facility # Participating Dentist

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3b. DELETING DEPENDENTS: Dependents to be Deleted in the Medical/Dental Plan							
Last Name, First Name, Middle Initial	**Social Security Number**	**Medicare Beneficiary Identifier**	**Gender**	**Relationship**	**Medical and/or Dental**	**Effective Date**	**Reason**
			☐ M ☐ F				
			☐ M ☐ F				

DELETED DEPENDENT(S) ADDRESS(ES):

4. IMPORTANT INFORMATION

- **Forms are required to be submitted by the 10th of the month** to be effective the 1st of the following month.
- Your first retirement payment or the first monthly payment following a health plan change may have more than one monthly deduction.
- ***Health plan enrollment and health subsidy eligibility is based on currently available information and is subject to change.*** LACERS reserves the right to make corrections to your health plan premium subsidy and eligibility upon receipt of any additional information received subsequent to your retirement date or eligible Survivor set-up. The amounts of City Service/Service Credit/Health Service Credit have not been verified and is subject to change.
- ***New Retirees who are eligible for Medicare:*** LACERS will enroll you and your eligible dependent(s) in the corresponding non-Medicare plan. Until all required Medicare-related forms and documents are received and processed by LACERS, the corresponding non-Medicare plan premiums and deductions will reflect in your retirement payment for a limited time period. Failure to enroll in Medicare and/or submit proof to LACERS in a timely manner will result in the termination of enrollment in your LACERS subsidy and medical plan coverage.
- ***LACERS Medicare requirement:*** LACERS requires that Retired Members, Eligible Surviving Spouses/Domestic Partners, and eligible dependents enroll in and maintain Medicare Part B, and, if eligible at no cost, Medicare Part A. Medicare-enrollees are responsible for paying their Medicare premiums and any Income-Related Monthly Adjustment Amounts (IRMAA) and penalties assessed by Centers of Medicare & Medicaid Services (CMS). Failure to maintain Medicare enrollment may result in the termination of your LACERS subsidy and medical plan coverage.
- ***CMS single Medicare plan requirement:*** CMS only allows enrollment in a single Medicare Advantage plan or Medicare Part D Prescription Drug plan. Enrolling in a non-LACERS Medicare plan or non-LACERS Medicare Part D prescription plan will cause your LACERS subsidy and medical coverage to be terminated.
- ***For those enrolled in the Kaiser Senior Advantage plan:*** If your Medicare coverage lapses, LACERS will enroll you and any dependents in the non-Medicare Kaiser HMO plan, for up to three months. Pursuant to the Los Angeles Administrative Code (LAAC) § 4.1111, 4.1115, 4.1126, and 4.1129.1, you will be ineligible for a medical subsidy and therefore responsible for full premium costs. You may cancel the non-Medicare Kaiser HMO coverage to avoid full monthly premium costs.
- **LACERS reserves the right to terminate your dependent's health plan coverage** should we discover your dependent is no longer eligible to participate in a LACERS health plan, including any Medicare non-compliance reason, e.g., lapse of Medicare Part B or enrollment to another plan.
- Pursuant to LACERS Board Rules, LACERS has the right to recover benefits paid when the Member or dependent was ineligible by offsetting against any benefits payable.
- For more information about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) or the Social Security Administration (SSA).

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4. IMPORTANT INFORMATION (Continued)

- Please review the LACERS Health Benefits Guide and the medical plan's Evidence of Coverage (EOC) for more information about your LACERS health benefits.

I have read and understand the information provided above.

Member's Signature **Date**

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**

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*.

Signature Required for Kaiser Permanente Plan **Date**

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

SUBMIT COMPLETED FORMS TO LACERS

SECURE DOCUMENT UPLOAD: **lacers.org/secure-document-upload**
EMAIL: **LACERS.health@lacers.org**
MAIL: **LACERS, Attn: Health Benefits Administration**
PO Box 512218, Los Angeles, CA 90051-0218
DROP OFF/VISIT: **977 N. Broadway, Los Angeles, CA 90012-1728**
FAX: **(213) 473-7284**

ADA NOTICE

As a covered entity under Title II of the Americans with Disabilities Act, the City of Los Angeles does not discriminate on the basis of disability and, upon request, will provide reasonable accommodations to ensure equal access to its programs, services and activities.