



2027 Employee Benefits Enrollment/Change Form

Benefit plan details can be found at <https://benefits.radychildrens.org>

Employee ID	First Name	Last Name

Date of Qualifying Life Event (QLE)*	
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*Please note that you must complete this enrollment form and provide supporting documentation within 31 days of your QLE to make benefit changes. If adding a child after birth or adoption, coverage will be effective on the date of birth or adoption. All other changes will be effective on the first of the month following the QLE date or the date you notify us, whichever is later.

Life Event Type		
☐ Open Enrollment ☐ Divorce / Legal Separation ☐ Loss / Gain of Coverage	☐ Marriage / Registered Domestic Partnership ☐ Birth / Adoption / Legal Guardianship ☐ Other: _____	☐ Dependent Death ☐ Change in FTE Status

Medical Plans	Coverage Level	Action
☐ Cigna Full Network HMO (PCP ID ¹ : _____) ☐ Cigna PPO ☐ Cigna HDHP 1850 ☐ Cigna HDHP 6000 ☐ SIMNSA HMO	☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family	☐ New Enrollment / Change ☐ No Change ☐ Waive

Dental Plans	Coverage Level	Action
☐ DeltaCare HMO (Facility Number ² : _____) ☐ Delta Dental PPO Standard ☐ Delta Dental PPO Buy-Up	☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family	☐ New Enrollment / Change ☐ No Change ☐ Waive

Vision Plans	Coverage Level	Action
☐ VSP Standard ☐ VSP Buy-Up	☐ Employee Only ☐ Employee + Spouse/DP ☐ Employee + Child(ren) ☐ Employee + Family	☐ New Enrollment / Change ☐ No Change ☐ Waive

Dependent Information							
Last Name	First Name	Relationship	Gender	DOB	Social Security Number	Coverage	PCP ID ¹ (Cigna HMO Only)
						☐ Medical ☐ Dental ☐ Vision	Medical _____ Dental _____
						☐ Medical ☐ Dental ☐ Vision	Medical _____ Dental _____
						☐ Medical ☐ Dental ☐ Vision	Medical _____ Dental _____
						☐ Medical ☐ Dental ☐ Vision	Medical _____ Dental _____

¹ Primary Care Physician (PCP) – Search for a Cigna in-network provider and obtain the PCP ID (not NPI Number) at www.cigna.com or call 800-244-6224.

² Search for a Delta Dental participating dentist at www.deltadentalins.com or call 800-422-4234; make sure the network is **DeltaCare USA**

SIMNSA HMO Enrollment Disclaimer (only applicable if enrolling in SIMNSA)

Upon applying for membership of Sistemas Medicos Nacionales, S.A. for me and eligible members of my family, I accept the following:

1. All services should be provided solely by SIMNSA providers, except in case of an Emergency as defined in the Plan document.
2. We shall not lend our member cards to others; doing so may result in immediate cancellation of coverage and penalties.
3. I understand that SIMNSA will obtain medical information for people listed on this application in order to administer the Plan.
4. I certify that the information on this application is valid and correct and that I understand the benefits and rules of this health Plan.
5. This Plan uses binding arbitration to settle all disputes arising under this Agreement. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered in California 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. For any disputes arising from services rendered in Mexico, Mexico law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. For more information, please refer to your Evidence of Coverage.

Al solicitar afiliación como miembro de Sistemas Médicos Nacionales, S.A. de C.V. (SIMNSA) para mí y miembros de mi familia que sean elegibles, acepto lo siguiente:

1. Todos los servicios deben ser proporcionados exclusivamente por los proveedores de SIMNSA, salvo emergencias (como explicado en los documentos de membresía).
2. No deben de prestar su tarjeta de membresía a cualquier otra persona, por la cual quedara sujeto a cancelación inmediata y cargos penales.
3. Estoy de acuerdo que SIMNSA obtendrá información médica acerca las personas que se incluyen en esta solicitud con el fin de administrar el Plan.
4. Certifico que la información que incluyo en esta solicitud es verídica y correcta y que comprendo los beneficios y reglamentos de este Plan de Salud.
5. Este plan usa el arbitraje atado exclusivamente para asentar toda disputa que surja bajo este acuerdo. Se entiende que cualquier disputa en cuanto a negligencia médica en caso de que algún servicio médico otorgado en California bajo este contrato era innecesario, no autorizado, inapropiado, negligente o incompetentemente otorgado, será determinado por la sumisión al arbitraje como es proporcionado por la ley de California, y no por un pleito o un proceso tribunal excepto como la ley de California estipula para la revisión jurídica de actos de arbitraje. Cualquier disputa que surja de servicios otorgados en México, la ley mexicana prevé revisión judicial de procedimientos arbitrales. Ambos partidos al aceptar este contrato renuncian a su derecho constitucional para tener cualquier disputa decidida en un tribunal de la ley ante un jurado, en lugar aceptan el uso de arbitraje. Para más información favor de referirse a su Constancia de Cobertura y Elegibilidad (CCE).

ENROLLMENT AGREEMENT / PAYROLL DEDUCTION AUTHORIZATION

I understand that if I elect to waive coverage now, I will not be permitted to enroll in the above plans (including, but not limited to, medical/dental/vision) until the next applicable enrollment period (unless I have a qualifying life event). *To cover your domestic partner, you must have a state-issued Declaration of Domestic Partnership form on file with Human Resources. Contact Human Resources for details.*

I acknowledge that the above information represents my enrollment elections. I understand that by signing this form I must remit post-tax premium payments to Tri-Ad, our third-party per diem benefits administrator, for any required contributions for the coverage(s) selected above, and failure to pay within the grace period may result in the cancellation of my benefits due to non-payment. I further understand that my elections cannot be changed or canceled until a future Open Enrollment period or a Qualifying Life Event/Status Change occurs. I represent to the best of my knowledge and belief, all statements and answers on this form are true, complete, and correct. I understand that omissions or misrepresentations with respect to the information provided may result in my coverage being void, and that I will be responsible for reimbursement of all claims paid during the period that myself and/or my dependent(s) were ineligible for coverage.

I authorize the release of medical information for myself and/or my dependents by my health care provider(s) for the purpose of coordinating patient care, administering claims and meeting legal requirements.

Employee Signature: _____

Date: _____