LACERS
LA CITY EMPLOYEES' RETIREMENT SYSTEM

Mailing Address: PO Box 512218, Los Angeles, CA 90051-0218
www.lacers.org | lacers.services@lacers.org | Mail Stop 175
(800) 779-8328 | RTT (888) 349-3996 | Fax (213) 473-7297

2024 Medical Plan Enrollment Form

(for Anthem Blue Cross/SCAN Health Plan/UnitedHealthcare ONLY)

1. SUBSCRIBER INFORMATION

Last Name	First Name, Middle Initial	Birth Date	Daytime Phone Number
Street Address	**City**	**State**	**Zip Code**
Retirement Effective Date:	**Email Address:**		

Status	Gender	Social Security Number	Medicare Beneficiary Identifier
☐ Single ☐ Domestic Partnership ☐ Married ☐ Divorced ☐ Widow(er)	☐ Male ☐ Female		

2. 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

***Anthem Blue Cross HMO will cover the individual(s) under age 65 or over age 65 with Medicare Part B only*

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

3. LIST SELF AND ANY ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE MEDICAL PLAN

Last Name, First Name, Middle Initial	Social Security Number	Medicare Beneficiary Identifier	Gender	Relationship	Birth Date (mm/dd/yy)
			☐ M ☐ F	**SELF**	
			☐ M ☐ F		

If you have additional eligible dependents to add, continue listing at the top of Page 2.

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers

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

3. LIST ANY ADDITIONAL ELIGIBLE DEPENDENTS TO BE ENROLLED IN THE MEDICAL PLAN *(continued)*

Last Name, First Name, Middle Initial	**Social Security Number**	**Medicare Beneficiary Identifier**	**Gender**	**Relationship**	**Birth Date** (mm/dd/yy)
			☐ M ☐ F		
			☐ M ☐ F		

Primary Care Physician Anthem Blue Cross HMO, SCAN Health Plan, UnitedHealthcare Medicare Advantage HMO subscribers

4. IMPORTANT INFORMATION

- Your first retirement payment or the first monthly payment following a health plan change may have more than one monthly deduction.
- **Your retirement or survivor documents must be completed and/or submitted within 90 days**, otherwise your coverage may be terminated and you will not be eligible for coverage until the next annual Open Enrollment period.
- ***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 forms and documents are received and processed by LACERS, the associated non-Medicare plan premiums and deductions will reflect in your retirement payment for a limited time period. Failure to enroll in Medicare and/or failure to submit proof to LACERS in a timely manner will result in the termination of the 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 responsible for paying their Medicare premiums, Income-Related Monthly Adjustment Amount (IRMAA), and penalties assessed by Centers for Medicare & Medicaid Services (CMS). Failure to maintain Medicare enrollment may result in the termination of your LACERS subsidy, medical plan coverage, and, if applicable, Retiree's basic Medicare Part B reimbursement.
- ***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 may cause your LACERS medical coverage and subsidy to be terminated.
- **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 Part B or enrolled in 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).
- 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**

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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**. I understand 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.

I understand that certain LACERS medical plans require enrollment in Medicare Parts A & B, or Part B only if not eligible for premium-free Part A. Should I fail to provide sufficient proof of proper Medicare enrollment and/or the required forms to enroll in a LACERS Senior (Medicare) Plan, I hereby authorize LACERS to enroll me and/or any dependents I have identified in a comparable non-Medicare plan, and I assume any increased premiums associated with that non-Medicare plan.

______________________________ ______________

Member's Signature **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.