

1. SURVIVOR INFORMATION

<input type="checkbox"/> MALE <input type="checkbox"/> FEM	LAST NAME	FIRST NAME	M.I.	<input type="checkbox"/> NAME CHANGE FORMERLY: _____
HOME ADDRESS		CITY	STATE	ZIP CODE
				HOME PHONE ()
BIRTH DATE	SOCIAL SECURITY NUMBER	CHECK ONE: <input type="checkbox"/> SURVIVOR OF RETIREE <input type="checkbox"/> SURVIVOR OF ACTIVE	NAME OF DECEASED SPOUSE AND EMPLOYEE NUMBER	

- I am not eligible to continue coverage through Aerospace because I am eligible for another group medical plan.
- I have reviewed the Medical Plans available and elect coverage under the plan checked below.

2. COVERAGE DEDUCTION

- Survivor Only Survivor & 1 Dependent Survivor & 2 or more Dependents

3. DEPENDENT INFORMATION

PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS TO BE ENROLLED (ATTACH ADDITIONAL ENROLLMENT FORM IF NECESSARY).

¹**For CaliforniaCare enrollees only** - Each person listed below must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected. Please designate a code for Medical Group or IPA.

	RELA-TIONSHIP	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO. (REQUIRED BY LAW)	BIRTH DATE	CALIFORNIA CARE ¹ MEDICAL GROUP/IPA PRIMARY CARE PHYSICIAN CODE	DIS- ABLED?
<input type="checkbox"/> ADD <input type="checkbox"/> DEL	You							<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD <input type="checkbox"/> DEL								<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD <input type="checkbox"/> DEL								<input type="checkbox"/> YES <input type="checkbox"/> NO

4. MEDICARE

Are you or other dependents eligible for Medicare? YES NO
 (Please submit copy of Medicare card.) Medicare I.D. No. - Survivor _____ Dependent _____

5. HOSPITAL-MEDICAL PLAN (Check Only One)

<input type="checkbox"/> BLUE CROSS OF CALIFORNIA, Nationwide Comprehensive Plan	<input type="checkbox"/> MD-IPA, Washington, D.C. - Indicate Facility Name/Number _____
<input type="checkbox"/> ¹ CALIFORNIA CARE, California/Blue Cross Sr. Secure	<input type="checkbox"/> AETNA US HEALTHCARE, Florida
<input type="checkbox"/> CALIFORNIA CARE/CENTRAL COAST (Over age 65)	<input type="checkbox"/> LOVELACE HEALTH, New Mexico Indicate Facility Name/Number _____
<input type="checkbox"/> ² KAISER-Southern California/Sr. Advantage	<input type="checkbox"/> PACIFICARE, Colorado/Secure Horizons Indicate Facility Name/Number _____
<input type="checkbox"/> ² KAISER-Northern California/Sr. Advantage	
<input type="checkbox"/> KAISER-Mid-Atlantic, Washington, D.C. Indicate Facility Name/Number _____	<input type="checkbox"/> PACIFICARE, Arizona/Secure Horizons Indicate Facility Name/Number _____

6. PAYMENT AGREEMENT - Choose One:

- I authorize The Aerospace Corporation to make the required deduction(s) from my Aerospace Employees' Retirement Plan monthly pension check as my contribution toward the cost of this insurance.
- OR:
- I agree to make quarterly payments in the form of a personal check or money order toward the cost of this insurance. I will be billed by the Accounting Department. Failure to pay premiums within the designated time frame will cause my coverage to lapse.

I certify that I have read the information on the reverse side of this form, including the Authorization to Obtain or Release Medical Information section, and that all of the statements and representations made by me on this form are true and correct.

² **Kaiser Foundation Health Plan Arbitration Agreement:** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my 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: _____ **DATE:** _____

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

The medical and/or dental carrier I have elected is authorized to obtain and release medical information in compliance with the insurance and Privacy Protection Act, Section 56.10 et. seq. of the California Civil Code. I authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of the carrier I have chosen any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled or added for purpose of review, investigation or evaluation of an application or a claim. I authorize the carrier I have chosen on the enrollment form or its 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 as long as is necessary to enable Blue Cross of California and its affiliates or any HMO to process claims.

ARBITRATION AGREEMENT

I want to enroll myself and those eligible members of my family listed on the enrollment form for participation in the plan elected. I understand that it is my responsibility to report any changes in the eligibility of my dependents; that the benefits and services of the elected plan are coordinated with those provided by any group, hospital or medical benefit or service plan; and that any controversy or dispute between myself (and/or any enrolled family member) and Blue Cross of California and its affiliates or any HMO (including its agents, staff, physicians, employers and providers) is subject to binding arbitration in lieu of a jury or court trial.

NON-PARTICIPATING PROVIDER

I understand that I am responsible for a greater portion of my medical costs when I use a non-participating Blue Cross provider. I understand that I am responsible for all of my medical costs when I use a non-participating HMO provider.

MEDICARE/MEDICAID COVERAGE DATA BANK (OBRA '93)

I understand that I am responsible for providing my eligible dependents' social security numbers which are required by OBRA '93. OBRA '93 established a Medicare/Medicaid Coverage data bank to hold data identifying any employer health plans that cover Medicare and Medicaid participants. This effort will assist Medicare/Medicaid to pay only on a secondary basis when there is an employer plan that should be the primary payer.

CHANGES TO YOUR BENEFITS

If you wish to add or delete dependents or make other changes to your Employee Benefits form, contact the Aerospace Employee Benefits Office (AGO), Mail Station M3/433, (310) 336-5107, or (800) 458-3892.

All changes must be supported by appropriate documentation. The following list contains examples of appropriate documentation, however, it is not inclusive: birth certificate, marriage certificate, decree of adoption, dissolution decree, power of attorney, appointment as guardian, appointment as conservator, and death certificate.