SFCityOption
THE EMPLOYER'S HEALTH CARE CHOICE

Program Finder Form

Help us find the right program for you!

Complete this form to help SF City Option determine if you qualify for SF MRA, SF Covered MRA, or Healthy San Francisco. After you submit this form, SF City Option will let you know which health care program you might qualify for within 1-3 weeks.

Get your results faster! For quicker processing, complete your Program Finder Form online at: https://sfcityoption.seamlessdocs.com/f/programfinder

**Required Field. (Complete all required fields. Your form cannot be processed if required information is missing.)*

*First Name:	*Last Name:
*Date of Birth (MM/DD/YYYY):	*Social Security Number *(LAST 4 DIGITS)*: SF City Option will use your SSN only to confirm: (1) whether an employer has contributed to SF City Option on your behalf, and (2) your eligibility or enrollment in an SF City Option health care program.
*Address:	
*City:	*State: / *Zip Code:
*Primary Phone Number: CHOOSE ONE OPTION ONLY ☐ Home ☐ Work ☐ Mobile ( ) —	Alternate Phone Number: CHOOSE ONE OPTION ONLY ☐ Home ☐ Work ☐ Mobile ( ) —
Email Address: By providing my email address, I agree to receive emails from SF City Option about which health care program I might qualify for and other program updates.	What is your preferred method of contact? CHOOSE ONE OPTION ONLY ☐ Mail ☐ Phone ☐ Email
*Employer Name(s):	
*How many people are in your household? (Include you, your spouse/domestic partner, and your dependents.)	*What is your annual household income? $

*How do you get your health coverage? CHOOSE ONE OPTION ONLY

- ☐ Health insurance purchased through Covered California
- ☐ Health insurance from my employer
- ☐ Health insurance from my spouse or parent's health plan
- ☐ Healthy San Francisco
- ☐ Medi-Cal
- ☐ Medicare
- ☐ I don't have any health coverage
- ☐ Other: ____________________

What is your preferred spoken language? CHOOSE ONE OPTION ONLY

- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Mandarin
- ☐ Tagalog
- ☐ Other: ____________

What is your preferred written language? CHOOSE ONE OPTION ONLY

- ☐ English
- ☐ Spanish
- ☐ Other: ____________
- ☐ Chinese
- ☐ Tagalog

- **I certify** that the information I provided in this SF City Option Program Finder Form is true and accurate.
- **I understand** that:

1. By submitting this SF City Option Program Finder Form, I am not automatically enrolled in SF Covered MRA or Healthy San Francisco. If I might be eligible for SF Covered MRA or Healthy San Francisco, I will need to confirm my program eligibility and enroll in the health care program that I qualify for at an in-person appointment.
2. If my application is approved for an SF MRA, only eligible payments made by my employer(s) will be transferred to a Medical Reimbursement Account. If approved for an SF MRA, I agree to have any future payments from my employer(s) deposited into a Medical Reimbursement Account until I enroll in another health care program through San Francisco City Option, such as SF Covered MRA or Healthy San Francisco.

*Signature: ______________________________ *Date: ______________

Mail your form to: San Francisco City Option • P.O. Box 194367, San Francisco, CA 94119

If you have any questions, please call Customer Service at **1(415) 615-5720** Monday through Friday, 8:30am-5:30pm Pacific Time.

For SF City Option Internal Use Only	RECEIVED DATE: ____________	PROCESSED DATE: ____________

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