SACRAMENTO CITY UNIFIED SCHOOL DISTRICT

CERTIFICATED MEDICAL, DENTAL, VISION, ENROLLMENT FORM

Employee Benefits Use Only:
Eligible Date______________________________

☐ New Enrollment ☐ Open Enrollment ☐ Change Health Plan ☐ Address Change ☐ Name Change *(if applicable - former name)*
☐ ADD DEPENDENTS ☐ DELETE DEPENDENT(S)
☐ Birth_________ ☐ Marriage_________ ☐ Divorce/Separation_________ ☐ Other: _________________
☐ Loss of Coverage ______ ☐ Adoption ☐ Child/No longer eligible_________

Medical Plan Information (select plan below)

(for carrier use only) ⇨ Group No.________________

☐ Health Net ☐ Kaiser ☐ Other ____

Medicare Coverage: Retired with Medicare ☐ A&B ☐ B only Must provide copy of Medicare Card

Employee Information

Married ☐ Yes ☐ No Widowed ☐

Social Security No. Last Name First MI Birthdate Sex (M / F)

Physical Address City State/ Zip Home Email

(_____)_________________(_____)_________________
Home Phone Work Phone Date of Hire Position Job Site No. of Hours Per Wk

______________________________/______________________________
For Health Net Enrollees Only: Name of Physician / Med Group Number / PCP Number Existing Patient ☐ Yes ☐ No

Dependent Information: Please note: If enrolling dependent(s) they will automatically be enrolled in the dental and life plans.

Last Name *(Sp/Dp)* First Name MI Address City State/Zip Social Security No.
PCP___________________ Med Group*___________________
Birthdate Sex (M / F) Marriage Cert ☐ Existing Patient ☐ Yes ☐ No

1____
Last Name *(Children)* First Name MI Address City State/Zip Social Security No.
PCP___________________ Med Group*___________________
Birthdate Sex (M / F) Birth Certificate ☐ Dependent Disabled ☐ Existing Patient ☐ Yes ☐ No

2____
Last Name *(Children)* First Name MI Address City State Zip Social Security No.
PCP___________________ Med Group*___________________
Birthdate Sex (M / F) Birth Certificate ☐ Dependent Disabled ☐ Existing Patient ☐ Yes ☐ No

3____
Last Name *(Children)* First Name MI Address City State Zip Social Security No.
PCP___________________ Med Group*___________________
Birthdate Sex (M / F) Birth Certificate ☐ Dependent Disabled ☐ Existing Patient ☐ Yes ☐ No

4____
Last Name *(Children)* First Name MI Address City State Zip Social Security No.
PCP___________________ Med Group*___________________
Birthdate Sex (M / F) Birth Certificate ☐ Dependent Disabled ☐ Existing Patient ☐ Yes ☐ No

Vision - Vision Service Plan *(For new enrollment only)*

☐ Employee Only Coverage ☐ Employee +1 Coverage ☐ Family Coverage <u>(defaults to family if not checked)</u>

DENTAL ☐ DELTA DENTAL ☐ PREMIER ACCESS

☐ Employee Only Coverage ☐ Employee +1 Coverage ☐ Family Coverage

<u>I have read and understand the terms of Mandatory Binding Arbitrations on the reverse of this application.</u> My signature below indicates my acceptance of these terms and that the information I have entered above on the application is true and correct.

TURN OVER AND SIGN

____ ______________________
Employee Signature Date

IMPORTANT

Arbitration – Health Net

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this application, and my signature below indicates that the information entered in this application is complete, true and correct to the best of my information and belief, and I accept these terms.

BINDING ARBITRATION AGREEMENT: I, the Applicant, understand and agree that any and all disputes between me (including any of my enrolled family members or heirs or personal representatives) and Health Net must be submitted to final and binding arbitration instead of a jury or court trial. This Agreement to arbitrate includes any disputes arising from or relating to the Evidence of Coverage or Certificate of Insurance or my Health Net membership or coverage, stated under any legal theory. This agreement to arbitrate any disputes applies even if other parties, such as health care providers or their agents or employees, are involved in the dispute. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties including Health Net are giving up their constitutional right to have their dispute decided in a court of law by a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. I understand that a more detailed arbitration provision is included in the Evidence of Coverage or Certificate of Insurance. Mandatory Arbitration may not apply to certain disputes if the Employer's plan is subject to ERISA, 29 U.S.C. §§ 1001-1461. My signature below indicates that I understand and agree with the terms of this Binding Arbitration Agreement and agree to submit any disputes to binding arbitration instead of a court of law.

Employee 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**

PREMIER ACCESS MANDATORY BINDING ARBITRATION: Premier Access Insurance Company uses binding arbitration to settle disputes, including to settle claims of dental malpractice. The insured understands and agrees that if a dispute arises in connection with this policy, the parties waive the right to a jury trial and must settle the dispute through binding arbitration. The Premier Certificate of Insurance contains a provision that further addresses this issue Premier Access Insurance Company does not use binding arbitration in connection with any dispute that an insured's life insurance coverage.

Medical Release: I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, hereby authorize the chosen carrier to release medical information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain medical information to or from other appropriate agencies and providers for the provision of necessary health care services, supplies and/or administrative services covered by the chosen carrier. This authorization shall remain in effect for the term of my and my Family Member(s) enrollment.

Right of Reimbursement: I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, hereby agree that in the event any health services provided to me or my Family Member(s) and covered by the chosen carrier are the primary financial responsibility of another party, because of other health coverage or by the act or omission of another person, I will fully inform the chosen carrier and will execute such assignments, liens or other documents which may be necessary to enable the above chosen carrier to recover the value of services and supplies provided. I further agree that in the event I or any of my Family Member(s) collect benefits or damages from any other party who has primary responsibility for services provided by the chosen carrier, I will immediately reimburse the chosen carrier to the extent of services and supplies received.

Plan Requirements: I, on my behalf and on behalf of my Family Member(s) listed on this enrollment application, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the chosen carrier's group agreement, and as the group agreement is amended.