Butte Schools Self-Funded Programs

Healthy Employees Supported by Quality, Well-Managed Programs

BSSP SUPPLEMENTAL ENROLLMENT FORM

SSN _____ **First** _____ **MI** _____ **Last** _____

DOB _____ **Marital Status** **Marriage Date** _____ **Title** _____

Hired _____ **Group** _____ **Status** _____ **Board** _____

Alt Address _____ **City** _____ **State** _____ **Zip** _____

Alt. Phone _____ **Alt. Email Address** _____

DOUBLE COVERED DISCOUNT You may be eligible for a 25% premium discount ONLY IF your spouse/RDP is an employee of the same or another BSSP-participating District and covered under a composite-rated BSSP Medical Plan. You must be covered as a dependent under your spouse's plan and he/she must also be covered as a dependent under your BSSP Medical plan to be eligible.

IF you meet the above criteria, please list your spouse's name and the District Name of which he/she is employed.

Spouse Name _____ **Spouse District Name** _____

ELECTED COVERAGE

Medical _____ **Dental** _____ **Vision** _____ **Voluntary Ambulance Benefit (MASA)** _____

Group Life _____ If yes, The Hartford Application for Voluntary Supplemental Life Form required.

Voluntary Employee _____ **Voluntary Spouse*** _____ **Voluntary Child(ren)*** _____ **STD/LTD (BGCCD, only)** _____

**Minimum $10K of Voluntary Employee Life must be selected in order to elect Voluntary Spouse and/or Voluntary Child Life.*

***Requires Evidence of Insurability.*

PLEASE READ CAREFULLY

Authorization to obtain or release medical information: Butte Schools Self-Funded Programs (BSSP) is authorized to obtain and release medical information in compliance with HIPAA and any other insurance and privacy protection act.

I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of Anthem Blue Cross, Navitus, Delta Dental, VSP, or BSSP any and all records of medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation or evaluation of an application or a claim.

I authorize BSSP or its agents, designees or representative to disclose to a hospital, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of the claim.

This authorization shall become effective immediately and shall remain in effect as long as necessary to enable BSSP to process claims and establish rates.

I understand I am responsible for a greater portion of my medical costs when I use a non-participating provider.

I understand any dispute between myself (and/or enrolled family member) and Anthem Blue Cross, Navitus, Delta Dental, VSP, or any affiliate, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the small claims court and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage the member and Anthem Blue Cross, Navitus, Delta Dental or VSP are giving up the right to have any dispute decided in a court of law before a jury.

I DECLARE, UNDER PENALTY OF PERJURY AND THE LAWS OF THE STATE OFCALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT. I WILL REPAY ANY CLAIMS PAID FRAUDULENTLY ON BEHALF OF MYSELF, MY SPOUSE/PARTNER AND/OR MY DEPENDENT CHILDREN.

Signature _____ **Date** _____

Information below is to be completed by district HR/Payroll Staff

All coverages effective: _____

Notes, District Signature and Date