SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: ______________ DISTRICT APPROVED INITIALS: ________

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT) ☐Certificated ☐Classified ☐Management	EMPLOYEE TYPE ☐ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

☐ MEDICAL
☐ DENTAL
☐ VISION
☐ LIFE

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO
IF YES, DO YOU HAVE MEDICARE? ☐YES ☐NO (Copy of Medicare card required)
TOTALLY DISABLED? ☐ YES ☐ NO

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO
(Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SPOUSE ☐ DOMESTIC PARTNER GENDER ☐ M ☐ F	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.

ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.
- NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- EFFECTIVE DATE: The effective date of coverage is subject to SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief; it is true and accurate with no omissions or misstatements.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, 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, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

____

Applicant Signature Required Date

Butte Schools Self-Funded Programs

Supporting Butte County-area educational agencies in employee wellness and school safety.

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, AmeriBen, 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, AmeriBen, 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, AmeriBen, 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

Dependent Eligibility Documentation Chart

The following verification documents are required to enroll a dependent in health benefit plans
SISC requires the Social Security Numbers for all dependents to be covered on the plans
SISC reserves the right to request additional documentation to substantiate eligibility

DEPENDENT TYPE	REQUIRED DOCUMENTATION
Spouse	• Page 1 of prior year's IRS Form 1040, Form 8879 IRS e-File Signature page, or Form 4868 Application for Extension (must include last 4 digits of spouse's SSN, black out financial information) showing "married" or "married filing separately" status. • Marriage Certificate for newly married couple where tax return is not available
Domestic Partner	• Certificate of Registered Domestic Partnership issued by State of California
Children, Stepchildren, and/or Adopted Children up to age 26	• Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Legal Adoption Documentation
Legal Guardianship up to age 18	• Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26	***Anthem Blue Cross (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Anthem Disabled Dependent Certification Form ***Kaiser (All items listed below are required)*** • Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) • Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) • Proof of 6 months prior creditable coverage • Completed Disabled Dependent Enrollment Application • Most recent Kaiser Certification notice (if available)