FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult & Community Ed.

Employee Benefits Enrollment Form

Instructions

You must complete and return all enrollment forms to the Business Department within 30 days of your coverage effective date (your first contractual work day). If you do not return this form within 30 days, your only option will be to waive medical coverage.

Type of Enrollment

☐ New Employee
☐ Open Enrollment
☐ Change/Add/Delete Coverage

For New Employees Only:
First Contractual Work Day _____/_____/_____

Reason for Change:
☐ Newborn/Adoption
☐ Marriage
☐ Divorce
☐ Family Status Change
☐ Other ____________________

Date of Event: ___________________________

Explanation of Event: _____________________

____

Employee Information

Employee Name (Last, First, MI) Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single	Job Title
Residence Street Address, Apt. No.	Work Phone Number (w/ ext.)	Number of Reg Scheduled Hrs
City, State, ZIP	Home Phone Number	E-mail Address

Dependent Information

This section must be completed by all employees. Please list ALL eligible dependents you wish to enroll in the medical, dental and vision plans. Children age 18 or under or who are age 24 and under and a full-time student are considered eligible.

Last Name, First Name, MI	Birthdate MM/DD/YY	Social Security #	F/T Student	Qualify as IRS Dependent?	Disabled?	Other Health Coverage? If Yes, Identify Carrier
Self		-- --	N/A	N/A	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female		-- --	N/A	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Son ☐ Daughter		-- --	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Son ☐ Daughter		-- --	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Son ☐ Daughter		-- --	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Son ☐ Daughter		-- --	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________
☐ Son ☐ Daughter		-- --	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes	☐No ☐Yes (Primary? ☐ Yes ☐ No) Carrier ________________ Eff. Date:________________

Are you enrolling a dependent who is over age 26? ☐ Yes ☐ No
If yes, Name of Dependent(s)______________________________
Coverage Start Date ___________Coverage End Date ____________

Carrier: ____
Reason for Termianting Coverage:___________________________
____

For HR Administrative Use ONLY (To be completed prior to submitting to carrier)	Effective Date of Coverage: _____/_____/_____	Spousal Contribution Applies? ☐Yes ☐No	Kaiser Permanente Enrollment Unit # ____ (required for all Kaiser Permanente enrollments)

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Medicare Information

Are You Retired? ☐No ☐Yes
If Yes:
Medicare Part A ☐No ☐Yes
Effective Date:_____

Medicare Part B ☐No ☐Yes
Effective Date:_____

Any Dependents have Medicare? ☐No ☐Yes
If Yes:
Medicare Part A ☐No ☐Yes
Medicare Part B ☐No ☐Yes

Name(s) of Medicare Dependent(s):

_____

If yes for Medicare for you and/or your Dependent(s), please provide all HIB numbers and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB #_____ Entitlement Reason: 65+Disabled /ESRD

Medicare Eff Date ____/____/____ Name _____

HIB #_____ Entitlement Reason: 65+Disabled /ESRD
Medicare Eff Date ____/____/____ Name _____

HIB #_____ Entitlement Reason: 65+Disabled /ESRD
Medicare Eff Date ____/____/____ Name _____

Full-Time Employee Medical Plan Choices

Select One Plan Option

	Employee Only	Employee + Spouse/RDP	Employee + Child(ren)	Employee + Family
☐ Anthem Blue Cross PPO (Prudent Buyer) #13016G	☐	☐	☐	☐
☐ Kaiser Permanente Traditional Plan (HMO) #991				

Part-Time Employee Health Plan Choices *(DO NOT COMPLETE IF YOU ARE A FULL TIME EMPLOYEE)*

*A pro-rated premium is required for less than full-time employees. This premium is based on the composite cost of benefits for all Fremont Education Associates (FEA) members. If spousal/RDP coverage is elected, a separate contribution applies **in addition** to the pro-rated premium.*

	Employee Only	Employee + Spouse/RDP	Employee + Child(ren)	Employee + Family
☐ OPTION 1: Elect Medical, Dental, Vision, Life*, and EAP Benefits (select one medical plan below):				
☐ Anthem Blue Cross PPO (Prudent Buyer) #13016G	☐	☐	☐	☐
☐ Kaiser Permanente Traditional Plan (HMO) #991				
☐ OPTION 2: Elect Dental, Vision, Life*, and EAP Benefits	☐	☐	☐	☐
☐ OPTION 3: Waive ALL Health Benefits (Separate Waiver Form Required)				

*Life insurance benefits apply to employees only. Dependents are not covered by this benefit.

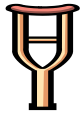
Core Employee Benefits

All full-time employees will automatically be enrolled in Life/AD&D, STD, and LTD benefits. In addition, full-time employees and their eligible dependents will automatically be enrolled in the dental, vision, and EAP plans. Part-time employees may make their benefits election in the section above.

Dental Plan #7094-0173
$50 Deductible
70-100% Preventive & Basic Care Benefit
70% Major Care Benefit
$1,500 Maximum Annual Benefit

Vision Plan #783001-0028
Eye Exam, Frames and Lenses Every 12 Months
$5 Copay

Life and AD&D Insurance #CT501206
Benefits Vary Based Upon Age



Short Term Disability #CT501206
75% Income Replacement
7 Day Waiting Period
Min Benefit $30.00 Per Day

Employee Assistance Program (EAP)
Confidential counseling and assistance
Phone assistance and up to 5 sessions face-to-face counseling

Long-Term Disability #CT501206
For Those with Less than 5 Years Service:
50% Income Replacement
Benefit Begins at End of STD Waiting Period

Employee Benefits Enrollment Form

Authorization and Signature

I have received and read all the materials explaining the Fremont Union High School District's Benefits Program. I understand that I am making a binding election concerning my benefits for a full Plan Year. I further understand that the salary reduction elections indicated above will remain in effect for the entire Plan Year and cannot be changed or revoked unless I experience a qualified change in family status as defined by the law.

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

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.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

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 Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice.If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end.

If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1 The date eligibility for COBRA Continuation Coverage ends, or

2 The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or

3 The date your employer discontinues coverage with Anthem Blue Cross, or

4 The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or

5 The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

Signtature Required on Next Page

Employee Benefits Enrollment Form

**Anthem Blue Cross Binding Arbitration: IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permittedand as provided by federal and California law, including but not limited to, the Patient Protection and AffordableCare Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING
DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

_____ _____

Signature Required for All Anthem Enrollees **Date**

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any 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), Kaiser Permanente Insurance Company (KPIC)*, 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 or coverage by KPIC, 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 and in the *Certificate of Insurance*.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

** Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.*

I have read and understand the provisions set out on this enrollment 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 my coverage being rescinded. I hereby elect and/or waive the above-indicated coverage for which I am eligible under The Fremont Union High School District Employee Benefit Plan. I certify that any and all information disclosed on this enrollment form is correct and that I am an employee of Fremont Union High School District and am regularly scheduled to work full or part-time according to the guidelines set forth in Fremont Education Association's Collective Bargaining Agreement.

Signature	Date