OAK GROVE SCHOOL DISTRICT
BENEFITS ENROLLMENT/CHANGE FORM

New Enrollment	☐ New Hire ☐ COBRA ☐ Re-Hire ☐ Qualifying Event	Effective Date:
	☐ Part-time to Full-time Employment Date:	
Status Change	☐ Add/Delete Dependent ☐ Address Change ☐ Name Change	Event Date:
	☐ Other Reason for Change	

1. EMPLOYEE INFORMATION

Last Name	First Name		MI	Social Security Number
Street Address	City	State	ZIP	Home Phone Number
Date of Birth	Site		Work Phone	
Sex: ☐ M ☐ F	Date of Hire	Work Email:	Home Email:	
☐ Full-time ☐ Part-time ☐ Retired	Employee Classification ☐ Classified ☐ Certificated ☐ Management ☐ Other			
	Marital Status ☐ Single ☐ Married ☐ Domestic Partnership			

2. HEALTH PLAN BENEFITS (PLEASE SIGN AND DATE THE APPROPRIATE AREA IN SECTION 6 OR 7)

Decline Medical	☐ Decline	☐ Cash in Lieu (CSEA and AFSCME Only) ☐ Current Group and Plan #
MEDICAL PLANS	**Sutter Health HMO** **United HMO** **United PPO - Traditional 90/60** **United PPO - Plus 70/50**	**Kaiser Permanente HMO Plan A** **Kaiser Permanente HMO Plan B** **Kaiser Permanente Plan D** **Kaiser Senior Advantage (must be enrolled in Medicare Part A&B)**

Sutter Health HMO ($20 Co-pay)	☐ Employee	☐ Employee+One Dependent	☐ Family	**Kaiser HMO Plan A ($15 Co-pay)**	☐ Employee ☐ Employee+One Dependent ☐ Family
United HMO ($20 Co-pay)	☐ Employee	☐ Employee+One Dependent	☐ Family	**Kaiser HMO Plan B ($30 Co-pay)**	☐ Employee ☐ Employee+One Dependent ☐ Family
United PPO Traditional 90/60	☐ Employee	☐ Employee+One Dependent	☐ Family	**Kaiser Deductible HMO Plan D $20 Co-pay)**	☐ Employee ☐ Employee+One Dependent ☐ Family
United PPO Plus 70/50	☐ Employee	☐ Employee+One Dependent	☐ Family	**Kaiser Senior Advantage (Must be enrolled in Medicare Part A & B)**	☐ Employee ☐ Employee+One Dependent ☐ Family

DENTAL	**Delta Dental Group No 906**		
☐ Employee	☐ Employee+One Dependent	☐ Family	☐ Decline
VISION	**VSP Group No 315001**		
☐ Employee	☐ Employee+One Dependent ($10/month)	☐ Family ($20/month)	☐ Decline

3. EMPLOYEE AND DEPENDENT INFORMATION

List yourself and any eligible dependents you wish to cover in this section. Please provide all information requested for each individual you are enrolling.

☐ Add ☐ Delete	Employee Name (Last, First, MI) Employee Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Spouse/DP Name (Last, First, MI) Spouse Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ Date of Marriage ________ Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Child Name (Last, First, MI) Child's Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ IRS Dependent? ☐ Y ☐ N Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Child Name (Last, First, MI) Child's Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ IRS Dependent? ☐ Y ☐ N Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Child Name (Last, First, MI) Child's Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ IRS Dependent? ☐ Y ☐ N Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Child Name (Last, First, MI) Child's Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ IRS Dependent? ☐ Y ☐ N Eligible for Medicare? ☐ Y ☐ N
☐ Add ☐ Delete	Child Name (Last, First, MI) Child's Soc. Sec. #	Sex ☐ M ☐ F	Date of Birth ________ IRS Dependent? ☐ Y ☐ N Eligible for Medicare? ☐ Y ☐ N

4. DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION

Name	Name of Other Insurance Carrier	Effective Date (MM/DD/YY)	Group Number	Is this yours or your dependent's primary coverage?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

5. PRIOR COVERAGE FOR PPO PLANS ONLY

Name	Start Date	End Date	Prior Carrier	Reason for Ending

6. REQUIREMENT FOR ALL KAISER PERMANENTE PLANS

Kaiser Foundation Health Plan Arbitration

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 Insurance.*

Employee Signature: _____ **Date:** _____

(Signature and date required for all Kaiser Permanente Plans)

7. REQUIREMENT FOR ALL UNITED/SUTTER HEALTH PLANS

United/Sutter Health Requirement for Binding Arbitration:

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 United/Sutter Health approval.

REQUIREMENT FOR BINDING ARBITRATION
I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from ERISA or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision:
The following provision does not apply to class actions:
IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT UNITED/SUTTER HEALTH 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. ***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 provided by California law, 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 UNITED/ SUTTER HEALTH ARE WAIVING THE RIGHT TO A JURY TRIAL 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.**

Employee Signature: _____ **Date:** _____

(Signature and date required for United/Sutter Health Plans)

8. WAIVER OF COVERAGE

Any eligible employee who certifies that: (i) the employee is enrolled in other employer-provided medical coverage through the employee's own employer or through a parent, spouse or domestic partner; or (ii) that the employee is enrolled in government-provided medical coverage (such as MediCal, MediCare, CHAMPUS or Tricare) may elect to waive the employee's right to medical coverage paid by the District. Any eligible employee who certifies that: (i) the employee's spouse/registered domestic partner is enrolled in employer-provided medical coverage through his or her employment; or (ii) that the spouse or registered domestic partner is enrolled in government-provided medical coverage may elect to waive the spouse or registered domestic partner's right to medical coverage paid by the District. Government-provided coverage does not include health insurance purchased on the health insurance marketplace pursuant to the Affordable Care Act. The election to waive medical coverage for the employee, spouse or registered domestic partner shall be made once a year during the open enrollment period, and cannot be changed until the next open enrollment period unless otherwise permitted as a life event or special enrollment under the Plan and applicable law and regulations. An employee who elects to waive his/her own medical coverage and/or his/her spouse or registered domestic partner's medical coverage shall be paid 80% of the District contribution amount negotiated per each bargaining unit. This payment is taxable. Employees may not add spousal/registered domestic partner coverage in one year in order to increase the cash option by electing a waiver in the following year. To waive coverage, the employee must complete and sign under penalty of perjury a voluntary waiver form identifying the other employer or government-provided coverage, the employer or government entity providing the coverage, and the name, address and telephone number of a contact person for such employer or government entity for purposes of verifying such coverage. A proof of group coverage must be provided.

Employee Signature: _____ **Date:** _____

(Signature and date required for Cash Waiver)

9. EMPLOYEE SIGNATURE AND CERTIFICATION OF INFORMATION ACCURACY

I understand and agree with the following statements:

☐ I authorize Oak Grove School District to make pre-tax deductions for my share of the cost of any of the coverage above.

☐ The individuals listed above are my current dependents.

☐ I declare that the information I have completed above is complete and true.

Employee Signature: _____ **Date:** _____

(Signature and date required for any enrollment or change to be processed)