San Bernardino City Unified School District

INSURANCE ENROLLMENT FORM

For Office Use Only
Medical Group No. ________________________
Dental Group No. ________________________

Employee's Social Security Number ____________________

Employee's Last Name, First, Middle Initial ____________________

Event Date MM/DD/YYYY ____________________

Address ____________________

Effective Date MM/DD/YYYY ____________________

City, State, Zip ____________________

Work Telephone (Area Code & Number) ____________________

Home Telephone (Area Code & Number) ____________________

Date of Birth ____________________

Check one box: ❐ New Hire/Retiree ❐ Annual Enrollment ❐ Change (**Must show documentation verifying Type of Family Change**)

Medical

Plan: ❐ Kaiser Permanente HMO Plan ❐ VSP Vision ❐ I choose to enroll ❐ I choose not to enroll
❐ Health Net of California ❐ HMO ❐ PPO

Covering: ❐ Emp./Retiree Only ❐ Spouse ❐ Spouse SBCUSD Employee? ❐ Dependent Child(ren) ❐ Domestic Partner

Dental

Plan: ❐ Delta Dental PPO ❐ Delta Care (HMO) ❐ MetLife (HMO)
❐ I choose to enroll ❐ I choose not to enroll

Covering: ❐ Emp. Only ❐ Spouse ❐ Spouse SBCUSD Employee? ❐ Dependent Child(ren) ❐ Domestic Partner

Life

❐ Certificated ❐ Classified ❐ Management

District Paid (For Full-Time Employees) ❐ I choose to enroll ❐ I choose not to enroll

Voluntary Employee Life Insurance Employee Paid ❐ I choose to enroll ❐ I choose not to enroll Coverage amount $____________________

Voluntary Spouse Life Insurance ❐ I choose to enroll ❐ I choose not to enroll
Complete Separate Life Insurance Form
Coverage amount $____________________
(can only enroll in 1/2 of spouse coverage)

Accidental Death And Dismemberment Insurance:

❐ I choose to enroll in the District paid $1,000 AD&D (Complete enrollment form)
❐ I choose to enroll in additional coverage (Complete enrollment form)
❐ I choose **not** to enroll

Coverage amount $____________________

BINDING ARBITRATION AGREEMENT (HEALTH NET): 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.

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 ____________________

I authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future.

Employee's or Retired Employee's Signature (Do Not Print) ____________________ Date Signed ____________________

BU-99 (Rev. 4/15) White - Employer Yellow - Employee