FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT ENROLLMENT/CHANGE FORM (**RETIREES-** if 65+request Medicare Enrollment form)

☐ New Retiree Enrollment ☐ Open Enrollment	☐ Change of Status	Retirement Date: _____
☐ Certificated ☐ Classified ☐ MGMT/CONF		
Change: ☐ Add Dependent ☐ Marriage/Divorce ☐ Name Change ☐ Change of Address ☐ Loss of Other Coverage ☐ Remove Dependent ☐ Other (Please Specify): _____		Effective Date: _____ Qualifying Event: _____ Qualifying Event Date: _____

GENERAL INFORMATION & ELECTIONS

1. RETIREE INFORMATION

Last Name:	First Name:	DOB:	☐ Male ☐ Female	Telephone No. ( )
Street Address:		City:	State:	Zip Code:
Home Email Address:				

2. RETIREE & FAMILY INFORMATION – Please list yourself and all eligible member to be enrolled

		Last Name	First Name	Age	Date of Birth (MM/DD/YYYY)	Social Security	Please indicate a coverage election for you and your Dependents		
							MEDICAL	DENTAL ☐ PPO ☐ DHMO	VISION
Self							☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ Spouse ☐ Registered Domestic Partner	☐ Male ☐ Female						☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child	☐ Male ☐ Female						☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child	☐ Male ☐ Female						☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

3. MEDICAL PLAN ELECTION

HEALTH PLAN CARRIER	HEALTH PLAN ADDITIONAL INFORMATION				PLAN SELECTION
Kaiser Permanente					
PREVIOUS KAISER MEMBER? ☐ SELF ☐ SPOUSE ☐ CHILD(REN) IF YES, EMPLOYEE MEDICAL RECORD NUMBER: _____	IF YES, MEDICAL RECORD NUMBER Spouse: _____ Child: _____ Child: _____				☐ KAISER $20 Copay ☐ KAISER NONSTOP
Sutter Health Plan	**Dependent HMO PROVIDER INFORMATION**				
Employee HMO PROVIDER INFORMATION: PRIMARY PHYSICIAN: PROVIDER ID #: PRIMARY CARE PHYSICIAN MEDICAL GROUP: EXISTING PATIENT: ☐ YES ☐ NO	PCP NAME Spouse: _____ Child: _____ Child: _____	MEDICAL GROUP Spouse: _____ Child: _____ Child: _____	PROVIDER # Spouse: _____ Child: _____ Child: _____	EXISTING PATIENT ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ SUTTER $15 COPAY ☐ Sutter NONSTOP
WESTERN HEALTH ADVANTAGE	**Dependent HMO PROVIDER INFORMATION**				
Employee HMO PROVIDER INFORMATION: PRIMARY PHYSICIAN: PROVIDER ID #: PRIMARY CARE PHYSICIAN MEDICAL GROUP: EXISTING PATIENT: ☐ YES ☐ NO	PCP NAME Spouse: _____ Child: _____ Child: _____	MEDICAL GROUP Spouse: _____ Child: _____ Child: _____	PROVIDER # Spouse: _____ Child: _____ Child: _____	EXISTING PATIENT ☐ YES ☐ NO ☐ YES ☐ NO ☐ YES ☐ NO	☐ WHA $20 Copay ☐ WHA NONSTOP

3. ARBITRATION

Kaiser Foundation Health Plan, Inc., 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

*Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

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Sutter Health Plus Member Agreement

Member accepts the terms, conditions and provisions of the Group Subscriber Contract and Combined Evidence of Coverage and Disclosure Form, upon completion and execution of this Enrollment Form.

BINDING ARBITRATION

Sutter Health Plus (SHP) handles and resolves Member disputes through grievance, appeal and Independent Medical Review processes. However, in the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, 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 binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Combined Evidence of Coverage and Disclosure Form.

Employee Signature: _____ Date:_____ Required for Sutter Health Plus Plan

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WHA Disclosures

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT 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 BINDING ARBITRATION.

Employee signature: _____ Date:_____

BENEFIT INFORMATION

Information regarding the benefits offered can be found on the District's benefits website at:
https://pcms.plansource.com
Username: FCUSDEmployee
Password: benefits (lower case)

You may also contact the Benefits Help Desk at (877) 374-2151 or csr@epicbrokers.com

FCUSD's Retiree Billing Administrator, **HealthEquity|WageWorks,** is where all your premium payments will be directed:

HealthEquity|WageWorks Customer Service (877) 722-2667 or www.healthequity.com/wageworks

AUTHORIZATION

The purpose of this agreement is to authorize the election of eligible benefits, which may be necessary to purchase the benefits elected. By signing below, I authorize my information to be sent to HeatlhEquity/WageWorks for billing of monthly premiums.

I have read, understood, and agree to the provisions set out on this form. Furthermore, I declare that the information I have completed on this enrollment form is complete and true. I understand that it is the basis on which coverage may be issued under the plan.

_____	_____	_____
Retiree Printed Name	Retiree Signature	Date