



# Sacramento City Unified School District

## (All Groups Excluding SCTA)

# Benefits Enrollment / Change Form

Rev 9/2026

Welcome to the California Schools VEBA. CalVEBA purchases and administers your health care benefits. What this means to you is that you get more benefits at a more reasonable cost than if your district purchased benefits on its own. Based on your district, you can enroll yourself and your eligible family members in a health plan.

CalVEBA is committed to helping you and your family be healthy and stay healthy. To make sure you choose the health plan and doctors that are best for you, we encourage you to research all of the plan benefits that are available to you as well as the medical groups and doctors you use. You can do this by visiting the California Office of the Patient Advocate at [www.opa.ca.gov](http://www.opa.ca.gov).

### WHAT YOU NEED TO KNOW

This form has the following three sections.

#### **Section 1. Employee Enrollment Information** *(ALL employees must complete Parts A, B and C of this section)*

- ☐ Fill in all the information requested *(Kaiser Permanente members plan members do NOT have to include a Primary Care Provider (PCP) name or number. HMO members can either include a PCP name OR leave the information blank and have their HMO carrier assign a PCP based on your zip code.)*
- ☐ Check with your employer to determine if domestic partnership coverage is available
- ☐ You can enroll your eligible dependents up to age 26
- ☐ Proof of permanent disability is required for dependents over age 26

#### **Section 2. Employee Signature Required for Binding Arbitration Agreement**

- ☐ All employees must sign the Binding Arbitration agreement as a requirement of the plan you select
- ☐ If you don't sign your health plan's Binding Arbitration agreement your enrollment may be denied

**SECTION 1. ENROLLMENT INFORMATION****A. Your Information** *(please print on all sections of form)*

|                                                                                                                                                                                                                                                      |  |                                  |                                                                                                        |                                                                                                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| School District Name:                                                                                                                                                                                                                                |  | Social Security No.(SSN):        |                                                                                                        | Date of Hire:                                                                                                                                                                                     |  |
| Name <i>(First, MI, Last)</i>                                                                                                                                                                                                                        |  |                                  |                                                                                                        | <input type="checkbox"/> Male <input type="checkbox"/> Female<br><input type="checkbox"/> Non-Binary                                                                                              |  |
| Residence Mailing Address:                                                                                                                                                                                                                           |  |                                  |                                                                                                        | Birth Date <i>(mm-dd-yy)</i> :                                                                                                                                                                    |  |
| City:                                                                                                                                                                                                                                                |  | State:                           | Zip Code:                                                                                              | Marital Status:<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced<br><input type="checkbox"/> Widow <input type="checkbox"/> Domestic Partner |  |
| Telephone: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work                                                                                                                                               |  |                                  | Telephone: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work |                                                                                                                                                                                                   |  |
| Email Address:                                                                                                                                                                                                                                       |  |                                  |                                                                                                        |                                                                                                                                                                                                   |  |
| PCP Name :<br><i>(UHC Members)</i>                                                                                                                                                                                                                   |  | PCP ID*:<br><i>(UHC Members)</i> |                                                                                                        | Are You an Existing Patient?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                          |  |
| Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "Yes," COBRA Qualifying Event & Effective Date _____<br><i>(Required)ie: Marriage, Newborn, Loss of Coverage, Newly benefit eligible, Return from LOA</i> |  |                                  |                                                                                                        |                                                                                                                                                                                                   |  |

\* if an incorrect or incomplete PCP ID is provided, we cannot guarantee PCP assignment

**D. Employer to Complete This Section**

|                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Group #/Plan Code:                                                                                                                                                                                                                                                                                                                                                                        |
| Requested Effective Date:                                                                                                                                                                                                                                                                                                                                                                 |
| Source of Enrollment/Change Event:<br><input type="checkbox"/> Open Enrollment<br><input type="checkbox"/> Employee Status Change<br><input type="checkbox"/> Dependent Status Change<br><input type="checkbox"/> New Hire<br><input type="checkbox"/> Rehire<br><input type="checkbox"/> Termination<br><input type="checkbox"/> QMCSO<br><i>(Qualified Medical Child Support Order)</i> |
| Enrollment Event Date:                                                                                                                                                                                                                                                                                                                                                                    |
| Employee Class:<br><input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Leave <input type="checkbox"/> COBRA                                                                                                                                                                                                                                         |

**B. Select Your Coverage**

| Enrollees                                                                                                    | Health Plans                                                                                                    |                                                                                                             |                                                                                                                        | Dental Plans                                        |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Self<br><input type="checkbox"/> Self + 1<br><input type="checkbox"/> Self + family | <b>Kaiser Permanente HMO</b><br><input type="checkbox"/> Kaiser 10<br><input type="checkbox"/> Kaiser HDHP 3400 | <b>Sutter Health HMO</b><br><input type="checkbox"/> Sutter 10<br><input type="checkbox"/> Sutter HDHP 1750 | <b>Western Health Advantage (WHA) HMO</b><br><input type="checkbox"/> WHA 15<br><input type="checkbox"/> WHA HDHP 1800 | <input type="checkbox"/> Delta                      |
|                                                                                                              |                                                                                                                 |                                                                                                             |                                                                                                                        | <b>Vision Plans</b><br><input type="checkbox"/> VSP |

**C. Dependent Information** *(attach additional sheets if necessary)*

|                                                                                                    |      |                                         |                                                                                         |                                 |                                          |                                                                                                                 |
|----------------------------------------------------------------------------------------------------|------|-----------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Add<br><input type="checkbox"/> Delete<br><input type="checkbox"/> Change | SSN: | Spouse/Domestic Partner Name            | <input type="checkbox"/> M<br><input type="checkbox"/> F<br><input type="checkbox"/> NB | Birth Date<br><i>(mm-dd-yy)</i> | Address <i>(if different from yours)</i> | PCP Name: _____<br>PCP ID.: _____<br>Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Add<br><input type="checkbox"/> Delete<br><input type="checkbox"/> Change | SSN: | Dependent Name <i>(First, MI, Last)</i> | <input type="checkbox"/> M<br><input type="checkbox"/> F<br><input type="checkbox"/> NB | Birth Date<br><i>(mm-dd-yy)</i> | Address <i>(if different from yours)</i> | PCP Name: _____<br>PCP ID.: _____<br>Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Add<br><input type="checkbox"/> Delete<br><input type="checkbox"/> Change | SSN: | Dependent Name <i>(First, MI, Last)</i> | <input type="checkbox"/> M<br><input type="checkbox"/> F<br><input type="checkbox"/> NB | Birth Date<br><i>(mm-dd-yy)</i> | Address <i>(if different from yours)</i> | PCP Name: _____<br>PCP ID.: _____<br>Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Add<br><input type="checkbox"/> Delete<br><input type="checkbox"/> Change | SSN: | Dependent Name <i>(First, MI, Last)</i> | <input type="checkbox"/> M<br><input type="checkbox"/> F<br><input type="checkbox"/> NB | Birth Date<br><i>(mm-dd-yy)</i> | Address <i>(if different from yours)</i> | PCP Name: _____<br>PCP ID.: _____<br>Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |

## SECTION 2. EMPLOYEE SIGNATURE REQUIRED FOR BINDING ARBITRATION AGREEMENT

Based on the health plan you enroll in, you must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

- Sign **A** below for **Kaiser plan**
- Sign **B** below for **Western Health Advantage plan**
- Sign **C** below for **Sutter Health plan**

### **A. Kaiser Foundation Health Plan Binding Arbitration Agreement** *(Read and sign this section ONLY if you enroll in a Kaiser Permanente Plan)*

#### **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.

☐ By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.

\_\_\_\_\_  
Employee Signature required for Kaiser Permanente Plan

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Date (month/day/year)

\* Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage 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.

### **B. Western Health Advantage Health Plan Binding Arbitration Agreement** *(Read and sign this section ONLY if you enroll in a Western Health Advantage Plan)*

#### **Western Health Advantage Binding Arbitration Agreement**

**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.**

**YOUR SIGNATURE**

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Name (please print)

\_\_\_\_\_  
Date (month/day/year)

**B. Sutter Health Plus Plan Binding Arbitration Agreement (Read and sign this section ONLY if you enroll in a Sutter Health Plan)**

**Sutter Health Plus Binding Arbitration Agreement**

- A. Sutter Health Plus 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, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.**
- B. 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.**
- C. Sutter Health HDHP health care service plans are issued and administered by Sutter Health Plan. California Schools VEBA facilitates enrollment for Sutter Health HMO and Sutter Health HDHP participants but does not underwrite or provide related benefit administration services. Coverage, claims administration, appeals, provider network administration, and benefits are governed by the Sutter Health Plan Subscriber Agreement and Evidence of Coverage.**

**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 EOC.**

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**Employee Signature**

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**Employee Name (please print)**

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**Date (month/day/year)**