SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: ______________ DISTRICT APPROVED INITIALS: ________

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT) ☐Certificated ☐Classified ☐Management	EMPLOYEE TYPE ☐ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO

IF YES, DO YOU HAVE MEDICARE? ☐YES ☐NO (Copy of Medicare card required)

TOTALLY DISABLED? ☐ YES ☐ NO

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO (Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SPOUSE ☐ DOMESTIC PARTNER GENDER ☐ M ☐ F	LAST NAME (PRINT)		FIRST NAME (PRINT)			SOCIAL SECURITY NO.
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)			SOCIAL SECURITY NO.
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)			SOCIAL SECURITY NO.
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)			SOCIAL SECURITY NO.
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.
- 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 SISC III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

I have read and understood the provisions outlined on this 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 the policy being rescinded. You are entitled to a copy of this signed authorization for your files. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. 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.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

____

Applicant Signature Required Date

Select Plan Type: ☐ 80% Plan ☐ 100% Plan