Santa Ana Unified School District

benefits

Employment Status

Enrollment/Change Form

Benefits Staff Use Only

Event Date: Effective Date: Enrollment Type:

Section 1 – Employee Information

Print or type in dark ink and select all required fields.

Last Name	First and Middle Name	Employee ID	Date of Birth	Social Security Number

Address	City	State	ZIP Code	Telephone Number

Gender	Classification	Marital Status	Are you married to another SAUSD employee?	If yes, what is your spouse's SAUSD ID?
Gender	Classification	Marital Status	Not Applicable	

Section 2 – Coverage Election

Select the coverage for you and your dependents. You and your dependents will be enrolled in the same plan(s).

Medical Election	Medical Tier
Medical Plan	Medical Tier

Dental Election	Dental Tier
Dental Plan	Dental Tier

Refusing: Not Applicable **for** Not Applicable

Section 3 – Dependent Information/Blue Shield HMO Physician Designation

Attach a separate sheet if necessary. Provide all required documents for new dependents.

EMPLOYEE

Last Name	First and Middle Name	BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician PCP ID (Not your Blue Shield ID)	Physician Name

DEPENDENT 1

Last Name	First and Middle Name	BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		Gender	Relation	Enroll In

DEPENDENT 2

Last Name	First and Middle Name	BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		Gender	Relation	Enroll In

DEPENDENT 3

Last Name	First and Middle Name	BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		Gender	Relation	Enroll In

DEPENDENT 4

Last Name	First and Middle Name	BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		Gender	Relation	Enroll In

Section 4 – Kaiser Foundation Health Plan Arbitration Agreement

Group 132731 Enrollment Unit

Kaiser members must read and sign the following 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.

KFHP Agreement Signature

KFHP Agreement Signature Date

Section 5 – SAUSD Enrollment/Change Form Signature (REQUIRED)

By signing this form, I under my elections will remain in effect, if I remain eligible, or until I make another election during an enrollment period. I wish to enroll myself, and my eligible dependents I've listed on this form, into the selections I have chosen. I understand that I am responsible for informing the District of any eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I certify, under penalty of perjury, that the above information in true and accurate to the best of my knowledge.

SAUSD Enrollment Form Signature

Enrollment Form Signature Date