



STAFF USE ONLY

Event Date: _____ Effective Date: _____ Enrollment Change Type: Add Drop Other: _____

Section 1 - Employee Information

Print or type in dark ink and check each applicable box.

Employee information fields: Last Name, First Name, Middle Name, Employee ID, Date of Birth, Social Security Number, Address, City, State, ZIP Code, Phone Number, Gender, Classification, Marital Status, Are you married to another SAUSD employee?

Section 2 - Selection of Plans

Select one medical and/or dental plan for you and your dependents. You and your dependents will be enrolled in the same plan(s). Provide all required documents for new dependents.

MEDICAL

Medical plan options: Kaiser Permanente HMO, Blue Shield Access+ HMO, Blue Shield Spectrum PPO, Blue Shield Trio ACO HMO, Single (Employee Only), 2 Party, Family.

DENTAL

Dental plan options: Delta Care USA DHMO, Delta Dental Incentive DPPO, Delta Dental Network DPPO, Single (Employee Only), 2 Party, Family.

REFUSAL OF COVERAGE: Complete this section if you are refusing coverage for you and/or your dependents. I am refusing MEDICAL coverage for: Myself, Spouse, Dependents. I am refusing DENTAL coverage for: Myself, Spouse, Dependents.

Section 3 - Dependent Information

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

Dependent information table with columns for Last Name, First Name, Middle Name, Social Security Number, Date of Birth, Gender, PCP ID, Physician Name, Relationship, 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.

Kaiser Arbitration Agreement Signature _____ Kaiser Arbitration Agreement Signature Date _____

Section 5 - SAUSD Enrollment Form Signature (REQUIRED)

Your enrollment request will not be processed if this section is not signed.

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 _____ SAUSD Enrollment Form Signature Date _____

Keep a copy of this form for your records