



**STAFF USE ONLY**

Event Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Enrollment Change Type:  Add  Drop  Other: \_\_\_\_\_

**Section 1 - Subscriber Information**

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

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/retiree?		
<input type="checkbox"/> Female	<input type="checkbox"/> Certificated <input type="checkbox"/> Management	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Male	<input type="checkbox"/> Classified	<input type="checkbox"/> Married <input type="checkbox"/> Separated	If yes, what is their SAUSD ID: _____			

**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.

<input type="checkbox"/> Kaiser Permanente HMO <small>Must sign Section 4</small>	<input type="checkbox"/> Blue Shield 65 Plus HMO <small>Additional Form Required</small>	<input type="checkbox"/> Blue Shield Access+ HMO <small>Full HMO Network</small>	<input type="checkbox"/> Single (Subscriber Only)	<p><b>REFUSAL OF COVERAGE</b> Complete this section if you are refusing coverage for you and/or your dependents.</p> <p>I am refusing <b>MEDICAL</b> coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p> <p>I am refusing <b>DENTAL</b> coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents</p>
<input type="checkbox"/> Kaiser Senior Advantage <small>Additional Form Required</small>	<input type="checkbox"/> Blue Shield Trio ACO HMO <small>Narrow HMO Network</small>	<input type="checkbox"/> Blue Shield Spectrum PPO	<input type="checkbox"/> 2 Party (Subscriber +1 dependent)	
<input type="checkbox"/> Delta Care USA DHMO	<input type="checkbox"/> Delta Dental Incentive DPPO	<input type="checkbox"/> Delta Dental Network DPPO	<input type="checkbox"/> Family (Subscriber +2 or more dependents)	
			<input type="checkbox"/> Single (Subscriber Only)	
			<input type="checkbox"/> 2 Party (Subscriber +1 dependent)	
			<input type="checkbox"/> Family (Subscriber +2 or more dependents)	

**Section 3 - Dependent Information**

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

<b>SUBSCRIBER</b>		Blue Shield HMO Members ONLY (Use this area to designate a primary care physician)	
Last Name _____	First Name, Middle Name _____	PCP ID (Not your Blue Shield ID) _____	Physician Name _____
<b>DEPENDENT 1</b>		Blue Shield HMO Members ONLY (Use this area to designate a primary care physician)	
Last Name _____	First Name, Middle Name _____	PCP ID (Not your Blue Shield ID) _____	Physician Name _____
Social Security Number _____	Date of Birth _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Relationship <input type="checkbox"/> Dental <input type="checkbox"/> Medical
<b>DEPENDENT 2</b>		Blue Shield HMO Members ONLY (Use this area to designate a primary care physician)	
Last Name _____	First Name, Middle Name _____	PCP ID (Not your Blue Shield ID) _____	Physician Name _____
Social Security Number _____	Date of Birth _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Relationship <input type="checkbox"/> Dental <input type="checkbox"/> Medical

**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 – CalSTRS Retirees Only (Certificated and/or Certificated Management)**

Important information about your health insurance premium payments and your CalSTRS pension check.

Payment for our health insurance premiums will be withdrawn from your CalSTRS pension check monthly. If you refund your pension, you will no longer be eligible for retirement benefits. Your signature acknowledges the monthly CalSTRS deduction from your pension check.

CalSTRS Acknowledgement Signature \_\_\_\_\_ CalSTRS Acknowledgement Signature Date \_\_\_\_\_

**Section 6 - 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