Santa Ana Unified School District

Post Eligible | 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
☐ Female
☐ Male

Classification
☐ Certificated
☐ Classified
☐ Headstart/Preschool
☐ Management
☐ SASPOA

Marital Status
☐ Divorced
☐ Domestic Partnership
☐ Married
☐ Separated
☐ Single
☐ Widowed

Are you married to another SAUSD employee?
☐ Yes ☐ No

If yes, what is your spouse's SAUSD ID?

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
☐ Blue Shield 65+ HMO (Retirees Only)
Additional Form Required
☐ Blue Shield Access+ HMO
☐ Blue Shield Spectrum PPO
☐ Blue Shield Trio ACO HMO
☐ Kaiser Senior Advantage (Retirees Only)
Additional Form Required
Must Sign Section 4
☐ Kaiser Permanente HMO
Must Sign Section 4
☐ No Medical Coverage

Medical Tier
☐ Single (Employee Only)
☐ 2 Party (Employee +1 Dependent)
☐ Family (Employee +2 or more Dependents)

Dental Election
☐ Delta Care USA DHMO
☐ Delta Dental Incentive DPPO
☐ Delta Dental Network DPPO
☐ No Dental Coverage

Dental Tier
☐ Single (Employee Only)
☐ 2 Party (Employee +1 Dependent)
☐ Family (Employee +2 or more Dependents)

Refusing: ☐ Dental ☐ Medical ☐ Dental and Medical **for** ☐ Myself ☐ My Spouse ☐ My Child(ren) ☐ My Spouse and Child(ren) ☐ All

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	PCP ID (Not your Blue Shield ID)	Physician Name

BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician

DEPENDENT 1

Last Name	First and Middle Name	PCP ID (Not your Blue Shield ID)	Physician Name

BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

DEPENDENT 2

Last Name	First and Middle Name	PCP ID (Not your Blue Shield ID)	Physician Name

BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

DEPENDENT 3

Last Name	First and Middle Name	PCP ID (Not your Blue Shield ID)	Physician Name

BLUE SHIELD MEMBERS ONLY - Use this section to designate a primary care physician

Social Security Number	Date of Birth	Gender	Relation	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ 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.

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 ________