San Juan Unified School District
Employee Benefits
Enrollment/Change Form
3738 Walnut Avenue, Carmichael CA 95608

BENEFIT USE ONLY
□ Proof of Dependency Received
□ Proof of Qualifying Event Received

SECTION I: EMPLOYEE INFORMATION (DO NOT FAX – FAXES WILL NOT BE ACCEPTED)

Last Name | **First Name** | **Middle Initial** | **Social Security Number**

Physical Address | **City** | **State** | **Zip Code**

Mailing Address (if different from above) | **City** | **State** | **Zip Code**

Email Address | **Primary Phone #** | **Alternative Phone**

SECTION II: REASON FOR ENROLLMENT/CHANGE /OR WAIVER

COVERAGE EFFECTIVE DATE: / /

□ New Hire/Newly Eligible Date: _____
□ Open Enrollment Changes:
□ Switch medical plan from _____to_____
□ Switch dental plan from _____ to_____
□ Add Dependent(s) □ Remove Dependent(s)
□ Qualifying Life Event (specify in next column)
Date of Qualifying Event:_____

Qualifying life event (supporting documentation required) Changes must occur within 30 days of the event date.
□ Marriage/Domestic partnership □ Divorce/Termination of domestic partnership/Legal separation
□ Birth of dependent □ Adoption or placement for adoption □ Death of family member
□ Change in dependent's employment status
□ Other qualifying event - subject to Benefits Office approval (please explain):
_____

SECTION III: BENEFIT PLAN COVERAGE ELECTIONS

Medical: □ Enroll/Change □ Decline Coverage		**Dental** □ Enroll/Change □ Decline Coverage		**Vision:** □ Enroll/Change □ Decline Coverage	
Plan	**Coverage Level**	**Plan**	**Coverage Level**	**Plan 00798301**	**Coverage Level**
□ **Kaiser #205 EU0000**	□ Employee □ Employee + 1	□ **Delta Dental #6689-0011**	□ Employee	□ **Employee Only Vision Division 09 Class 02**	□ Employee
□ **Western Health Advantage #104910**	□ Employee + Family	□ **Delta Care #1103-0001** **Office #** _____	□ Employee + 1 □ Employee + Family	□ **Enhanced Vision Division 19 Class 19**	□ Employee + 1 □ Employee + Family

SECTION IV: EMPLOYEE/DEPENDENT INFORMATION

Medical Action	Dental Action	Vision Action	Relationship*	Name (Last, First, MI)	Social Security #	Birth Date (mm/dd/yyyy)	Sex M / F	Existing Medical Patient Y/N	WHA – Physician Name/Number or Group
□ Add □ Drop	□ Add □ Drop	□ Add □ Drop	Employee						
□ Add □ Drop	□ Add □ Drop	□ Add □ Drop							
□ Add □ Drop	□ Add □ Drop	□ Add □ Drop							
□ Add □ Drop	□ Add □ Drop	□ Add □ Drop							
□ Add □ Drop	□ Add □ Drop	□ Add □ Drop							

*Spouse, Domestic Partner, Child or Step-Child. If other, please specify. You must provide documentation on each dependent when adding to coverage.(e.g., birth certificate, marriage license, etc.) If enrolling a Domestic Partner, attach a completed Domestic Partner Affidavit along with required documentation. Requested changes will not be processed until documentation is received by the Benefits Office.

SECTION V: EMPLOYEE AUTHORIZATION

I hereby certify that this information is true and correct. I further certify that I have read and understood the arbitration agreement on the back of this form for the medical plan I have elected, if applicable, and I agree to the statement's term and conditions. This I attest under penalty of perjury and subject to all applicable insurance fraud laws. I understand that by signing this form, I am electing my benefits on the effective date shown. Further I authorize my employer to deduct employee insurance contributions on a pre-tax basis.

Employee Signature:_____ Date:_____

 (Original Signature – ELECTRONIC SIGNATURE WILL NOT BE ACCEPTED)

ARBITRATION AGREEMENTS FOR MEDICAL CARRIERS

.KAISER FOUNDATION HEALTH PLAN ARBITRATION 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.

Employee Name (Please Print) **Social Security Number**

Employee Signature (Required) **Date**

WESTERN HEALTH ADVANTAGE ARBITRATION AGREEMENT

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee Name (Please Print) **Social Security Number**

Personal Email (optional)

Employee Signature (Required) **Date**