San Juan Unified School District
Employee Benefits Enrollment/Change Form

Complete this form and return it to the Benefits Department

Section I – Employee Information — Social Security Number: - -

			☐Single ☐Married	( ) -
Last Name	First Name	Middle Initial	Marital Status	Home Telephone
Physical Address		City	State	Zip Code
Mailing Address		City	State	Zip Code

Section II – Enrollment/Coverage Options — Effective Date of Coverage / /

Check the box(es) that apply to the benefit election/changes

☐ New Hire Date Employed	☐ Return from Leave Date
☐ Open Enrollment	☐ Add ☐ Delete dependents (Complete Section III)
☐ Change in enrollment Reason(qualifying event)	Event date / /
☐ Change my name as shown above Former name	
☐ Change my address as shown above	☐ Decline medical coverage (Waiver form required)

Select one: MEDICAL PLAN	Employee Only	Employee + One	Employee + Family
☐ Kaiser Premier # 205	☐	☐	☐
☐ Western Health Advantage #104910	☐	☐	☐
Select one: DENTAL PLAN			
☐ Delta Dental #6689-0011 *Coverage code*	☐	☐	☐
☐ DeltaCare USA (family coverage) #01103-0001	Enter DeltaCare dental office code:		
VISION			
☐ VSP Vision (Employee coverage only) # 00798301 Division 09 Class 02			

Section III – Coverage for You and Your Dependents and PCP Selection

To enroll yourself and your dependents, or to add or delete dependents from your current coverage, provide the information requested in this section. **In order to add dependents you must provide proof of eligibility (i.e. marriage certificate/domestic partnership/birth certificate) as well as Social Security Numbers**.

Add/ Delete		Enrolled Member *(Last Name, First Name, MI)*	Social Security Number	Sex	Birth Date	Physician Name PCP ID#	Med Group	Existing Patient Y/N
	SELF							
	Spouse							
	Reg. D/Ptnr.							
	Dep.							
	Dep.							
	Dep.							

Section IV – Employee Authorization — *Signature also required on reverse*

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 page of this form for the medical plan I have elected, if applicable, and I agree to the statement's terms 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.

Signature **Date**

SIGNATURE REQUIRED

ARBITRATION AGREEMENTS FOR MEDICAL CARRIERS

KAISER PERMANENTE HMO ENROLLEES - KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT: I UNDERSTAND THAT (EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO A MEDICARE APPEALS PROCEDURE, AND, IF MY GROUP MUST COMPLY WITH ERISA, CERTAIN BENEFIT-RELATED DISPUTES) ANY DISPUTE BETWEEN MYSELF, MY HEIRS OR OTHER ASSOCIATED PARTIES ON THE ONE HAND AND HEALTH PLAN, ITS HEALTH CARE PROVIDERS, OR OTHER ASSOCIATED PARTIES ON THE OTHER HAND, FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATED TO MEMBERSHIP IN HEALTH PLAN, INCLUDING ANY CLAIM FOR MEDICAL OR HOSPITAL MALPRACTICE, 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 MY 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.

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

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Employee Signature **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.**

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

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Personal Email (optional)

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Employee Signature **Date**