



PPO MEDICAL ENROLLMENT FORM

For District Use Only

GROUP MEDICAL NO.

EFFECTIVE DATE

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I. PERSONAL INFORMATION

LAST NAME (Print)	FIRST NAME (Print)	M.I.	1 <input type="checkbox"/> MALE 2 <input type="checkbox"/> FEMALE	BIRTHDATE MO DAY YR
STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE NO. Area Code ()
SOCIAL SECURITY NO.	HIRE/REHIRE DATE MO DAY YR	EMPLOYER	OCCUPATION	

II. MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

Are you retired? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, do you have Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Copy of Medicare card required)</i> If yes, Part A effective date _____ Part B effective date _____	Do any of your dependents have Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(Copy of Medicare card required)</i> If yes, Part A effective date _____ Part B effective date _____
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III. EMPLOYEE & FAMILY INFORMATION Proof of eligibility required (i.e. birth/marriage certificate/domestic partnership validation).

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	Is eligible for other health plan?	Is enrolled in other health plan?	QUALIFIES AS IRS DEPENDENT	FULL-TIME STUDENT	DATE OF BIRTH	AGE	TOTALLY DISABLED
SELF					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE/ DOMESTIC PARTNER Gender <input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO					<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO

- IV.** I understand it is my responsibility to notify SISC once a dependent or former dependent is no longer eligible, such as following a divorce or when a dependent child over the age of 19 no longer meets the eligibility requirements (full time student or IRS dependent) and that I may be financially liable to SISC in the event I fail to notify it and the claim of a non-eligible person is paid.
- V. DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required dues.
- VI. NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- VII. HIV Testing Prohibited:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
- VIII. EFFECTIVE DATE:** The effective date of coverage is subject to SISC III approval.
- IX.** Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

X. SIGNATURE OF UNDERSTANDING - APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files.

Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, SISC, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

XI. ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name _____

Hire date (mm/dd/yyyy) _____

Group number _____

Enrollment unit _____

Effective enrollment/
change date (mm/dd/yyyy) _____

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance)

New group: Yes No

New Hire (complete sections A, B, C, D)

Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) HMO Plan Deductible Plan Other _____

Loss of Other Coverage (complete sections A, B, C, D)

Other (please specify) _____

Name change (complete sections A, B, C, D) From: _____

To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known) _____

Social Security No. _____

Name (Last, First, MI) _____

Birth Date (mm/dd/yyyy) _____

Gender M F

Home Address _____

City _____

State _____

ZIP _____

Work Phone _____

Home Phone _____

E-mail _____

Ethnicity _____

Preferred Language _____

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

Add Delete Spouse Domestic partner

Gender M F

Social Security No. _____

Spouse/domestic partner name: _____

Birth Date (mm/dd/yyyy) _____

Former last name (if any): _____

Medical Record No. _____

Add Delete Child Student

Gender M F

Social Security No. _____

Dependent name: _____

Birth Date (mm/dd/yyyy) _____

Relationship: _____

Medical Record No. _____

Add Delete Child Student

Gender M F

Social Security No. _____

Dependent name: _____

Birth Date (mm/dd/yyyy) _____

Relationship: _____

Medical Record No. _____

Add Delete Child Student

Gender M F

Social Security No. _____

Dependent name: _____

Birth Date (mm/dd/yyyy) _____

Relationship: _____

Medical Record No. _____

Do any of dependents above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI): _____

Address: _____

D. 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, relatives, 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 (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/Applicant signature _____

Date _____

Employer signature _____

Date _____

*Additional documentation may be required.

Basic Life/AD&D Insurance

Enrollment Form

Underwritten by: **United of Omaha Life Insurance Company**



Brought to you by:



Mutual of Omaha

Employee Section (Please print clearly. Required fields are marked with an asterisk (*).)

*Last Name		*First Name:		MI:
Address:		City:	State:	Zip:
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
<input type="checkbox"/> Active Full Time Employee <input type="checkbox"/> Active Part Time Employee <input type="checkbox"/> Retired				

Complete this section if Dependent Coverage is offered by your District

Spouse Name (Last, First, MI) _____ # of Dependent Children _____

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)
 If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

Enrollment Information
 Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

Agreement and Signature
 I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependents may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.
 By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. I understand that payment of premium does not ensure eligibility for coverage.

SIGNATURE OF EMPLOYEE _____ **DATE** ____/____/____

Waiver of Group Insurance
 Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)), I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own expense.
 The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

District Use Only

Employer's Name: Antelope Valley Union High School District	Group ID: G000ABIH
City: Lancaster	State: CA
Hire Date: _____	Effective Date: _____
District #: 64246	Occupation: _____
Account #: _____	Amount of Coverage: \$50,000.00
Classification (circle one) <input type="checkbox"/> Classified <input type="checkbox"/> Certificated	Weekly Hours Worked: _____
Employee Occupation: _____	Coverage for: (check one) <input checked="" type="checkbox"/> Employee <input type="checkbox"/> Employee & Dependents