



Universal Enrollment Form

Medical/Dental/Vision - For Active, Retiree, COBRA, Surviving Spouse Participants

FOR OFFICE USE ONLY: Plan Type _____ Plan Code _____ Coverage Code _____ Effective Date _____

Plan Selection:				
<input type="checkbox"/> PPO Medical Plan	<input type="checkbox"/> EPO Medical Plan	<input type="checkbox"/> Kaiser Permanente HMO Medical Plan	<input type="checkbox"/> Delta Dental of California	<input type="checkbox"/> Vision Service Plan (VSP)
Employee Information:				
Name (Last, First, M.I.)		Social Security Number	Date of Birth	Hire Date
Home Address			Home Phone:	
			Alternative Phone:	
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legal Separation		Classes of Coverage:	
Hrs worked per week: _____	Job Occupation: _____	Campus Location: _____	<input type="checkbox"/> FT Faculty	<input type="checkbox"/> Confidential
			<input type="checkbox"/> PT Faculty	<input type="checkbox"/> Supervisor
			<input type="checkbox"/> Classified SEIU	<input type="checkbox"/> Administrator
			<input type="checkbox"/> Classified CSEA	<input type="checkbox"/> Board Member
			<input type="checkbox"/> Retiree	<input type="checkbox"/> Surviving Spouse
			<input type="checkbox"/> Article 19 Retiree	<input type="checkbox"/> COBRA Enrollee
Does your spouse have a dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who is covered: <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent children				
If Delta Dental, indicate group number: _____				
<input type="checkbox"/>	MEDICAL	Cov Code	<input type="checkbox"/>	VISION
<input type="checkbox"/>	Employee Only	001	<input type="checkbox"/>	Employee Only
<input type="checkbox"/>	Employee + Spouse	002	<input type="checkbox"/>	Employee + Spouse
<input type="checkbox"/>	Employee + Domestic Partner (DP)	003	<input type="checkbox"/>	Employee + Domestic Partner (DP)
<input type="checkbox"/>	Employee + Child	004	<input type="checkbox"/>	Employee + Child
<input type="checkbox"/>	Employee + Children	005	<input type="checkbox"/>	Employee + Children
<input type="checkbox"/>	Employee + Family	006	<input type="checkbox"/>	Employee + Family
<input type="checkbox"/>	Employee + DP + Family	007	<input type="checkbox"/>	Employee + DP + Family
<input type="checkbox"/>	WAIVED			
This Election is for: (Check one)			COBRA/Surviving Spouse Qualifying Event Date: (Check one)	
<input type="checkbox"/>	New Enrollment		Date: _____	
<input type="checkbox"/>	Marriage/Divorce: _____ Effective date		<input type="checkbox"/> Termination of Employment	
<input type="checkbox"/>	Name Change: _____ Former name		<input type="checkbox"/> Change of Employment Hours	
<input type="checkbox"/>	Birth of Child		<input type="checkbox"/> Marriage of Covered Child	
<input type="checkbox"/>	Adoption or Placement of Adoption		<input type="checkbox"/> Death of Subscriber	
<input type="checkbox"/>	Court Ordered Coverage: Please attach a copy of court order		<input type="checkbox"/> Divorce or legal separation	
<input type="checkbox"/>	Deleting Dependent(s): _____ Effective date		<input type="checkbox"/> Dependent reached age limit according to PLAN	
<input type="checkbox"/>	Loss of Other Health Coverage. Please provide termination coverage letter from other employer		<input type="checkbox"/> Dependent can no longer be claimed for tax purpose according to the IRS	
<input type="checkbox"/>	Reinstatement of Coverage – Return from Unpaid Leave		<input type="checkbox"/> Retirement (when ineligible for District paid benefits)	
<input type="checkbox"/>	Address Change			
<input type="checkbox"/>	COBRA Continuation: _____ Effective date			
<input type="checkbox"/>	Other: _____			

For Kaiser Permanente Participants Only:

Are you now or have you ever been a Kaiser Permanente member? Yes No

If "Yes", please list your Kaiser Permanente Medical Record Number: _____

Medical / Dental / Vision Coverage:

(A)dd (C)hange (D)elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth	Sex	Children 19 and over, IRS Dependent?	Disabled?
	Self					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Daughter/Son					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you included stepchildren as dependents? YES NO If "yes" indicate name/s: _____

Do your stepchildren reside with you? YES NO

Are they dependent upon you for support and maintenance? YES NO

(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)

Do you or your dependents have other health coverage? If yes, please complete this section.

	Name	Name and address of other insurance Carrier	Effective Date
Self			
Spouse/ DP			
Daughter /Son			
Daughter /Son			
Daughter /Son			

Medicare Section

Are you retired?..... Yes No

If yes.....Part A Yes No
.....Part B Yes No

Do any of your dependents have Medicare?..... Yes No

If yes, for your dependents.....Part A Yes No
.....Part B Yes No

Name(s) of Medicare Dependent(s)

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their SSN and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

SSN # _____
Entitlement Reason: Over 65 Disabled OTHER
Effective Date of Medicare ____/____/____
Name _____

SSN # _____
Entitlement Reason: Over 65 Disabled OTHER
Effective Date of Medicare ____/____/____
Name _____

Payroll Deduction Contributions

The plan administrator may reduce or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and the amount may change in the future.

Kaiser Permanente Arbitration Agreement

I apply for Health Plan membership for myself and my covered family dependents. We agree to abide by the provisions of the Service Agreement and Health Plan policies. We 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 me, 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.

United Healthcare

Non-Participating Provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider

Arbitration Agreement:

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Your Authorization:

I acknowledge that I have received and read the enrollment materials for the Employee Benefits Program and I have read the information on this form. I acknowledge that the information submitted represents my enrollment choice(s) and I am authorizing contributions to be withheld from my pay for the healthcare covered selected.

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis.

This signature also verifies the accuracy of the information on this form.

I have read, understand, and agree to the terms and conditions above.

Signature of Employee: _____ Date: _____

Employer Information (to be completed by Human Resources Department)

Authorized Signature of Employer : _____ Effective Date of Coverage: _____