

Medical Enrollment Form

For Part-Time Faculty

FOR OFFICE USE ONLY: Plan Type_____ Plan Code_____ Coverage Code_____ Effective Date_____

Plan Selection:																																																									
<input type="checkbox"/> Kaiser Medical Plan		<input type="checkbox"/> New Enrollee	<input type="checkbox"/> renew only																																																						
Employee Information:																																																									
Name (Last, First, M.I.)		Social Security Number	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: <input type="checkbox"/> PT Faculty <input type="checkbox"/> COBRA Enrollee																																																						
Hrs worked per week: _____	Job Occupation: _____	Campus Location: _____																																																							
<table border="1"> <thead> <tr> <th></th> <th>MEDICAL</th> <th>Cov Code</th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>Employee Only</td> <td>001</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + Spouse</td> <td>002</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + Domestic Partner (DP)</td> <td>003</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + Child</td> <td>004</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + Children</td> <td>005</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + Family</td> <td>006</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Employee + DP + Family</td> <td>007</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>WAIVED</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					MEDICAL	Cov Code				<input type="checkbox"/>	Employee Only	001				<input type="checkbox"/>	Employee + Spouse	002				<input type="checkbox"/>	Employee + Domestic Partner (DP)	003				<input type="checkbox"/>	Employee + Child	004				<input type="checkbox"/>	Employee + Children	005				<input type="checkbox"/>	Employee + Family	006				<input type="checkbox"/>	Employee + DP + Family	007				<input type="checkbox"/>	WAIVED				
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This Election is for: (Check one)		COBRA/Surviving Spouse Qualifying Event Date: (Check one)																																																							
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Marriage/Divorce: _____ Effective date <input type="checkbox"/> Name Change: _____ Former name <input type="checkbox"/> Birth of Child <input type="checkbox"/> Adoption or Placement of Adoption Court Ordered Coverage: Please attach a copy of court order <input type="checkbox"/> Deleting Dependent(s): _____ Effective date <input type="checkbox"/> Loss of Other Health Coverage. Please provide termination coverage letter from other employer <input type="checkbox"/> Reinstatement of Coverage – Return from Unpaid Leave <input type="checkbox"/> Address Change <input type="checkbox"/> COBRA Continuation: _____ Effective date <input type="checkbox"/> Other: _____		Date: _____ <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Change of Employment Hours <input type="checkbox"/> Marriage of Covered Child <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Dependent reached age limit according to PLAN <input type="checkbox"/> Dependent can no longer be claimed for tax purpose according to the IRS <input type="checkbox"/> Retirement (when ineligible for District paid benefits)																																																							

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 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			

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.

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 check during the pay periods of October through June of the plan year.

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: _____