CALIFORNIA SCHOOLS VEBA

Enrollment Form

Kaiser Permanente & UnitedHealthcare

Welcome to the California Schools VEBA. VEBA purchases and administers your health care benefits. What this means to you is that you get more benefits at a more reasonable cost than if your district purchased benefits on its own. Based on your district, you can enroll yourself and your eligible family members in a health plan through either Kaiser Permanente or UnitedHealthcare.

VEBA is committed to helping you and your family be healthy and stay healthy. To make sure you choose the health plan and doctors that are best for you, we encourage you to research all of the plan benefits that are available to you as well as the medical groups and doctors you use. You can do this by visiting the California Office of the Patient Advocate at www.opa.ca.gov.

WHAT YOU NEED TO KNOW

This form has the following three sections.

Section 1. Employee Enrollment Information *(ALL employees must complete Parts A, B and C of this section)*

- ☐ Fill in all the information requested *(Kaiser Permanente members plan members do NOT have to include a Primary Care Provider (PCP) name or number. UnitedHealthcare (UHC) HMO members can either include a PCP name OR leave the information blank and have UHC assign a PCP based on your zip code.)*
- ☐ Check with your employer to determine if domestic partnership coverage is available
- ☐ You can enroll your eligible dependents up to age 26
- ☐ Proof of permanent disability is required for dependents over age 26

Section 2. Employee Signature Required for Binding Arbitration Agreement

- ☐ All employees must sign the Binding Arbitration agreement as a requirement of the plan you select
- ☐ If you don't sign your health plan's Binding Arbitration agreement your enrollment may be denied

Section 3. UnitedHealthcare (UHC) Information

- ☐ Employees enrolling in a UHC Plan must review and sign the "Release of Medical Information" section

IMPORTANT NOTE: If you enroll in the **UnitedHealthcare Performance HMO Plan:**

- ☐ You and any dependents must ALL enroll in the same network
- ☐ You and each of your dependents will remain in your selected network and HMO plan for the ENTIRE plan year
- ☐ You and your dependents can choose separate Medical Groups as long as they are in the same network
- ☐ You must select a Primary Care Provider—if you do not select a PCP, one will be assigned to you

SECTION 1. ENROLLMENT INFORMATION

A. Your Information *(please print on all sections of form)*

School District Name: San Diego Community College District			Date of Hire:
Last Name: First Name:		MI:	☐Male ☐Female ☐Non-Binary
Residence Mailing Address:	City:	State:	Zip Code:
Home Telephone:	Work Telephone:	Birth Date *(mm-dd-yy)*:	
Social Security No. *(SSN)*:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Domestic Partner		
PCP Name (UHC Members):	PCP Number (UHC Members):	Are You an Existing Patient? ☐Yes ☐No	
Are you currently on COBRA? ☐Yes ☐No If "Yes," COBRA Qualifying Event & Effective Date______________________________		Your Email Address:	

D. Employer to Complete This Section

Group #/Plan Code:

Requested Effective Date:

Source of Enrollment/Change Event:
☐Open Enrollment
☐Employee Status Change
☐Dependent Status Change
☐New Hire
☐Rehire
☐Termination
☐QMCSO
(*Qualified Medical Child Support Order)*

Enrollment Event Date:

Employee Class:

☐Active ☐Retired ☐Leave ☐COBRA

B. Select Your Coverage

Enrollees	Health Plan				
☐Self ☐Self + 1 ☐Self + family	☐ **Kaiser Permanente HMO $0**	☐ **UnitedHealthcare (UHC) Performance HMO - Network 1**	☐ **UHC Alliance HMO $20/30**	☐ **UHC Harmony HMO $10**	☐ **UHC Journey HMO with HRA**

C. Dependent Information *(attach additional sheets if necessary)*

☐Add ☐Delete ☐Change	Spouse/Domestic Partner Name	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ___________________ PCP No.:______________________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ___________________ PCP No.:______________________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ___________________ PCP No.:______________________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ___________________ PCP No.:______________________ Existing Patient? ☐Yes ☐No
☐Add ☐Delete ☐Change	Dependent Name *(Last, First, MI)*	☐M ☐F ☐NB	Address *(if different from yours)*	Birth Date *(mm-dd-yy)*	SSN:	PCP Name: ___________________ PCP No.:______________________ Existing Patient? ☐Yes ☐No

SECTION 2. EMPLOYEE SIGNATURE REQUIRED FOR BINDING ARBITRATION AGREEMENT

Based on the health plan you enroll in, you must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

- Sign **A** below for **Kaiser plan**
- Sign **B** below for **UnitedHealthcare plan**

A. Kaiser Foundation Health Plan Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a Kaiser Permanente Plan)*

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.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature required for Kaiser Permanente Plan	**Employee Name** (please print)	**Date** (month/day/year)

* Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration 1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

B. UnitedHealthcare Plan Members Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a UnitedHealthcare Plan)*

UnitedHealthcare Binding Arbitration Agreement

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND 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 CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, 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 THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHTS TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

YOUR SIGNATURE

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

Other Medical Coverage Information: This section must be completed (Attach sheet if necessary.)

On the day my coverage starts with San Diego Community College, will you, your spouse or any of your dependents be covered under any other medical health plan or policy ? YES NO -- Name of other carrier: _____

If you have dual coverage and your spouse's primary insurance is not through the district, their primary coverage would be through their own employer or primary insurance plan. For dependents, primary coverage is determined by the birthday rule, meaning the parent whose birthday (month and day, not year) comes first in the calendar year provides the primary insurance.

I acknowledge that if I possess insurance coverage elsewhere and opt for insurance through the San Diego Community College District, I understand that insurance provided by the District constitutes an HMO and is deemed my primary insurance. Consequently, I will be accountable for any outstanding charges incurred outside the coverage provided by this insurance.

Signature: _____

SECTION 3. UNITEDHEALTHCARE PLAN *(UHC plan members must sign "Authorization to Release Medical Information" below)*

HIV Disclaimer
"California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage."

Legal Entities Disclaimer
Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by UnitedHealthcare Insurance Company, United HeathCare Services, Inc., PacifiCare Health Plan Administrators, Inc., Prescription Solutions or Optum Health Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Authorization to Release Medical Information
I authorize UnitedHealthCare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and Affiliates to make decisions regarding eligibility, enrollment and risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ *By checking this box, I am indicating that I have carefully read the above "Authorization to Release Medical Information" and agree to its terms.*

Employee Signature	**Employee Name** (please print)	**Date** (month/day/year)

DELTA DENTAL®
Delta Dental Plan of California

Enrollment — Non Voluntary

Group Name
San Diego Community College District / VEBA

Delta Group/Division Number
6714 - _ _ _ _

A ENROLLEE (Complete this section for new enrollment or change of status)

Name
Last First Middle Initial

Social Security Number
_____-_____-_____
(Member I.D. Number)

Date Employed
____/____/____
Month Day Year

Action Requested
☐ New enrollment ☐ Reinstatement
☐ COBRA enrollment ☐ Transfer
☐ Change in enrollment ☐ Rehire

Please enroll me in the following:
☐ Delta Dental
☐ Delta Vision

Birthdate
Month Day Year
_____/_____/_____

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated

Do you have dependent children?
☐ Yes
☐ No

Does your spouse have a dental plan? ☐ Yes ☐ No
If yes, who is covered: ☐ yourself ☐ spouse ☐ dependent children
If Delta Dental, indicate group number: _____

Employee Classification
☐ Certificated ☐ Full-time ☐ Part-time
☐ Classified ☐ Hourly ☐ Retired
☐ Salaried ☐ COBRA

Mailing Address _____ Telephone Number (_____)_____
City _____ State _____ ZIP code _____

FOR DELTA USE ONLY
Effective Date of Coverage
Family Indicator Code

☐ **COBRA Enrollment**
I understand that I may be required by the employer to pay for COBRA benefits

Note: If Dependent is enrolling under own social security number, the original Member's social security number must be supplied.

_____
Benefits previously received under Social Security Number (Member I.D. Number)

Qualifying Date _____/_____/_____
Month Day Year

B Change to Existing Enrollment (Complete all sections that apply)

☐ Name change ☐ Add new dependent ☐ Delete dependent ☐ Address change listed above

Reason for change _____ Effective date of change _____/_____/_____
Month Day Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) / First / Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	**Marriage/Divorce Date** Month Day Year	**Spouse's Social Security Number**
	*	*	____/____/____	____/____/____	

Child Name Last (if different) / First / Middle Initial	**Add/ Delete**	**Sex** M F	**Birthdate** Month Day Year	If Child is 19 years or older (check one) **Full-time Student**	If Child is 19 years or older (check one) **Disabled**	**Child's Social Security Number**
	*	*				
	*	*				
	*	*				
	*	*				

D Signature (Form must be signed to be processed)

I understand there is no contribution required by me for coverage of myself or my dependents. (Exception — See COBRA enrollment) I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature _____ Date _____