UHC Bronze Plan Enrollment Form

Welcome to the California Schools VEBA. VEBA purchases and administers your District's health care benefits. And, while you are not eligible for the District's standard plans, VEBA is pleased to offer the Bronze Plan to employees who worked at least 20 hours/week in 2014

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
- ☐ 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 UHC Bronze Plan you select
- ☐ If you don't sign the plan's Binding Arbitration agreement, your enrollment may be denied

Section 3. UnitedHealthcare (UHC) Information

- ☐ Employees must review and sign the "Release of Medical Information" section

SECTION 1. ENROLLMENT INFORMATION

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

School District Name:				Date of Hire:	
Last Name:	First Name:			MI:	☐Male ☐Female
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:	PCP Number:			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 ☐QMCSO (*Qualified Medical Child Support Order)* Enrollment Event Date:
Employee Class:
☐Active ☐Retired ☐Leave ☐COBRA

B. Select Your Coverage

Health Plan Enrollees	Health Plan
☐Self ☐Self + 1 Dependent ☐Self + 2 or more Dependents	**☐UnitedHealthcare Bronze Plan**

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

☐Add ☐Delete ☐Change	Spouse/Domestic Partner Name	☐M ☐F	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	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	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	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	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

You must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

UnitedHealthcare Plan Members Binding Arbitration Agreement

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

My signature below indicates that I have carefully read the above “Binding Arbitration” language and agree to its terms.

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

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.

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