BERKELEY UNIFIED SCHOOL DISTRICT MEDICAL ENROLLMENT/CHANGE FORM

Enrollment:	❑ New Enrollment	❑ Open Enrollment	❑ Change of Status	
Termination:	❑ Kaiser	❑ Health Net		
Change:	❑ Add Dependent	❑ Add Newborn/Newly adopted child	❑ Change of Name	❑ Change of Address
	❑Loss of Other Coverage	❑ Remove Dependent	❑COBRA _____ (18 or 36 months)	❑ Other (Please Specify) _____
Qualifying Event: _____ Qualifying Event Date: _____				

EFFECTIVE DATE	MEDICAL GROUP NUMBER	SUBGROUP/ENROLLMENT UNIT

1. EMPLOYEE INFORMATION

LAST NAME (PRINT)	FIRST NAME (PRINT)	M.I.	☐ Male ☐ Female	TELEPHONE NO. ( )	ANNUAL EARNINGS	DATE OF HIRE

STREET ADDRESS	CITY	STATE	ZIP

2. MEDICAL ELECTION

Kaiser Permanente
☐HMO "High Option" ☐HMO "Low Option"

HealthNet
☐HMO "High Option" ☐HMO "Low Option" ☐POS ☐PPO
☐Medicare COB HMO ☐Medicare COB PEPO ☐FlexNet ☐Seniority Plus

3. EMPLOYEE & FAMILY INFORMATION – Please list yourself and all eligible members to be enrolled. (Attach additional sheet if necessary.)

	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	AGE	SOCIAL SECURITY	Primary Care Physician (PCP) Required for Health Net HMO			TOTALLY DISABLED
							PCP#	MG #	Current Patient	
SELF									☐ Yes ☐ No	☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female									☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter									☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter									☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter									☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter									☐ Yes ☐ No	☐ Yes ☐ No

4. DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this section including Medicare (if applicable)

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE	GROUP NUMBER	Is this your or your dependent's primary coverage?	DOES IT COVER MENTAL HEALTH	DOES IT COVER MEDICAL
SELF					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
SPOUSE					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT #1 ABOVE					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT #2 ABOVE					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT #3 ABOVE					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DEPENDENT #4 ABOVE					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5. PRIOR COVERAGE

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE**, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or **FORMER CARRIER** must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	NAME	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
SELF					
SPOUSE					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

6. MEDICARE SECTION

Do you or any of your Dependents:			Name(s) of Medicare Dependent(s):	If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).	
Have Medicare?		☐ Yes ☐ No			
If yes for you:	Part A	☐ Yes ☐ No	1._____	HIB#_____	HIB#_____
	Part B	☐ Yes ☐ No	2._____	Entitlement to Medicare ☐ Over 65 ☐ Disabled ☐ ESRD	Entitlement to Medicare ☐ Over 65 ☐ Disabled ☐ ESRD
If yes for your dependent:	Part A	☐ Yes ☐ No	3._____	Effective Date of Medicare_____	Effective Date of Medicare_____
	Part B	☐ Yes ☐ No	4._____	Name_____	Name_____

7. AUTHORIZATION – SIGNATURE REQUIRED – Please sign only once under the appropriate carrier

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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.

EFFECTIVE DATE: The effective date of coverage is subject to carrier approval.

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, 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 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.*

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

Health Net Acceptance of Coverage:

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the DBP Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DBP Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

_____ _____

Employee Signature Date

Health Net Preexisting Conditions and Creditable Coverage

Your coverage under the PPO, HSA, PPO, EPO and Flex Net benefit plans may be subject to pre-existing condition limitations for a maximum period of six months from the effective date of your enrollment. In accordance with state and federal law, Health Net Life Insurance company will credit any prior coverage that you document at the time you apply to enroll in PPO, HSA PPO, EPO or FLEX NET, provided the prior coverage qualifies as "creditable coverage" as defined under federal and state law. Creditable coverage will be applied to offset (in part or whole) the pre-existing condition limitation, which may apply to your coverage under this policy. If you're unable to provide documentation of bona fide creditable coverage at enrollment time, Health Net Life Insurance Company may provide assistance in obtaining the necessary documentation upon request. Note: Prior coverage, which is interrupted by a period of 63 days (or 180 days if your previous employer terminated the coverage) or more, does not qualify as creditable coverage.