# SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
## MEDICAL, DENTAL, VISION, ENROLLMENT FORM

*Employee Benefits Use Only:*
Eligible Date_____

*Indicate reason for application:* ☐ Member ☐ Spouse ☐ Child

☐ New Enrollment ☐ Open Enrollment ☐ Change Health Plan ☐ Address Change ☐ Name Change *(if applicable - former name)*
☐ ADD DEPENDENTS ☐ DELETE DEPENDENT(S)

☐ Birth_____ ☐ Marriage_____ ☐ Divorce/Separation_____ ☐ Other: _____
☐ Loss of Coverage_____ ☐ Adoption ☐ Child/No longer eligible_____

## Medical Plan Information (select plan below)

*(for carrier use only)* ⇨ Group No._____

☐ Kaiser (HMO) ☐ Western Health (HMO) ☐ Sutter Health Plus (HMO)
☐ Kaiser (HSA) ☐ Western Health (HSA) ☐ Sutter Health Plus (HSA) Previous Kaiser ID No._____

## Employee Information

Social Security No. | Last Name | First | MI | Birthdate | Sex (M / F) | Married ☐ Yes ☐ No

Physical address | City | State | Zip | County | Email Address

(____)_____ (____)_____
Home Phone | Work Phone | Date of Hire | Position | Job Site | No. of Hours Per Wk

For WHA and Sutter : PCP *(Primary Care Physician)* | Med Group* (*Medical Group*) | Existing Patient ☐ Yes ☐ No

*Please indicate coverage selection(s)* ☐Dental ☐Vision ☐ Life

## Dependent Information:

Last Name *(Spouse)* | First Name | MI | Address | City | State | Zip | Social Security No.

Birthdate | Sex (M / F) | PCP_____ | Med Group*_____
Existing Patient ☐ Yes ☐ No
*Please indicate dependent coverage selection(s)* ☐Medical ☐Dental ☐Vision ☐ Life

1_____
Last Name *(Children)* | First Name | MI | Address | City | State | Zip | Social Security No.

Birthdate | Sex (M / F) ☐ Disabled | PCP_____ | Med Group*_____
Existing Patient ☐ Yes ☐ No
*Please indicate dependent coverage selection(s)* ☐Medical ☐Dental ☐Vision ☐ Life

2_____
Last Name *(Children)* | First Name | MI | Address | City | State | Zip | Social Security No.

Birthdate | Sex (M / F) ☐ Disabled | PCP_____ | Med Group*_____
Existing Patient ☐ Yes ☐ No
*Please indicate dependent coverage selection(s)* ☐Medical ☐Dental ☐Vision ☐ Life

3_____
Last Name *(Children)* | First Name | MI | Address | City | State | Zip | Social Security No.

Birthdate | Sex (M / F) ☐ Disabled | PCP_____ | Med Group*_____
Existing Patient ☐ Yes ☐ No
*Please indicate dependent coverage selection(s)* ☐Medical ☐Dental ☐Vision ☐ Life

## DENTAL

☐ DELTA DENTAL ☐ PREMIER ACCESS
☐*EE only* ☐EE + 1 ☐Family

## Vision - Vision Service Plan *(For new enrollment only)*

☐ Employee Only Coverage ☐ Employee +1 Coverage ☐ Family Coverage (defaults to family if not checked)

I have read and understand the terms above and on the reverse of this application. My signature below indicates my acceptance of these terms and that the information I have entered above on the application is true and correct.

_____ _____ *TURN OVER AND SIGN*
Employee Signature: Date:

11/9/22 Rev

# IMPORTANT

**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.**

_____ _____

**Signature Required for Kaiser Permanente Plan** **Date**

**Medical Release:** I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, hereby authorize the chosen carrier to release medical information to official government agencies and to other individuals when required under appropriate federal or state law, or pursuant to legal process and to release and obtain medical information to or from other appropriate agencies and providers for the provision of necessary health care services, supplies and/or administrative services covered by the chosen carrier. This authorization shall remain in effect for the term of my and my Family Member(s) enrollment.

**Right of Reimbursement:** I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, hereby agree that in the event any health services provided to me or my Family Member(s) and covered by the chosen carrier are the primary financial responsibility of another party, because of other health coverage or by the act or omission of another person, I will fully inform the chosen carrier and will execute such assignments, liens or other documents which may be necessary to enable the above chosen carrier to recover the value of services and supplies provided. I further agree that in the event I or any of my Family Member(s) collect benefits or damages from any other party who has primary responsibility for services provided by the chosen carrier, I will immediately reimburse the chosen carrier to the extent of services and supplies received.

**Plan Requirements:** I, on my behalf and on behalf of my Family Member(s) listed on this enrollment application, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations and other terms and conditions of the chosen carrier's group agreement, and as the group agreement is amended.

**Mandatory Binding Arbitration:** As more fully set out in the Group Agreement / Evidence of Coverage / Policy / Certificate, we agree that binding arbitration is the final process for the resolution of any dispute arising out of or relating to the health plan or Policy / Certificate. This does not apply to malpractice claims brought against participating providers. By enrolling in any of these plans, Employer and Members waive their constitutional right to a trial before a jury or judge.