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

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		
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	☐ **Kaiser 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.

Kaiser Permanente Plan Members Binding Arbitration Agreement

Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any 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), Kaiser Permanente Insurance Company (KPIC)*, 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 or coverage by KPIC, 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 and in the Certificate of Insurance.

☐ 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)

*** Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.**