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:			Date of Hire:
Social Security No.*(SSN)*:	Name *(First, MI, Last)*		☐Male ☐Female ☐Non-Binary
Residence Mailing Address:			Birth Date *(mm-dd-yy)*:
City:	State:	Zip Code:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Domestic Partner
Telephone: ☐Mobile ☐Home ☐Work		Telephone: ☐Mobile ☐Home ☐Work	
Email Address:			
PCP Name : *(UHC Members)*	PCP ID*: *(UHC Members)*		Are You an Existing Patient? ☐Yes ☐No

Are you currently on COBRA? ☐Yes ☐No
If "Yes," COBRA Qualifying Event & Effective Date____________________
(Required)ie: Marriage, Newborn, Loss of Coverage, Newly benefit eligible, Return from LOA

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** *(If your district offers a choice, select a plan below)* ☐High Plan ☐Low Plan	☐**UnitedHealthcare (UHC) PHMO** *(If your district offers the Performance HMO, you must choose one network for your family.)* ☐Network 1 ☐Network 3	☐**UHC Alliance HMO** ☐Alliance 10 ☐ Alliance 15 ☐ Alliance 20 ☐ Alliance 20/30	☐**UHC Harmony HMO** ☐Harmony 10 ☐Harmony 15 ☐Harmony 20 ☐Harmony 20/30	☐ **UHC Journey HMO** ☐VEBA Direct Journey ☐Harmony ☐Alliance	☐**VEBA Direct HMO** ☐VEBA Direct 10 ☐VEBA Direct 15 ☐VEBA Direct 20 ☐VEBA Direct 20/30	☐ **UMR Select Plus** ☐ **SIMNSA HMO**

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

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

** if an incorrect or incomplete PCP ID is provided, we cannot guarantee PCP assignment*

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**
- Sign **C** below for **SIMNSA 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)

C. SIMNSA Plan Members Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in the SIMNSA Plan)*

Upon applying for membership in Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) for me and eligible members of my family, I accept the following: 1. All services should be provided solely by SIMNSA providers, except for emergency or urgent care (as defined in the Plan document). 2. We shall not lend our member cards to others; doing so may result in immediate cancellation of coverage and penalties. 3. I understand that SIMNSA will obtain medical information for people listed on this application in order to administer the Plan. 4. I certify that the information on this application is valid and correct and that I understand the benefits and rules of this health Plan. 5.This Plan uses binding arbitration to settle all disputes arisingunderthisAgreement. Itisunderstoodthatanydisputeastomedicalmalpractice,thatis,astowhetheranymedicalservice srenderedinCaliforniaunderthiscontractwereun- necessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional righttohaveanysuchdisputedecidedinacourtoflawbeforeajury,andinsteadareacceptingtheus eofarbitration. Formoreinformation,pleaserefertoyourEvidenceofCoverage.

☐ *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)

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)