Fresno Unified School District
2309 Tulare Street Fresno, CA 93721
(559) 457-3520 Fax No. (559) 457-3760

# SPECIAL ENROLLMENT FORM
BENEFITS ELIGIBLE EMPLOYEES

## 1. EMPLOYEE INFORMATION

| LAST NAME | FIRST NAME | FUSD EMPLOYEE I.D. / SSN | ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP<br>☐ ACTIVE ☐ RETIREE ☐ LEAVE |
|---|---|---|---|
| | | | |

| MAILING ADDRESS | BIRTHDATE | TELEPHONE NO. | ☐ MALE ☐ FEMALE |
|---|---|---|---|
| | | | |

| CITY | STATE | ZIP CODE | DEPARTMENT / SCHOOL |
|---|---|---|---|
| | | | |

## 2. OTHER HEALTH INSURANCE INFORMATION

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE? ☐ FUSD ☐ OTHER: _____

Are you or any family members covered by another group plan? ☐ NO ☐ YES _____
GROUP NAME

****PLEASE NOTIFY THE BENEFITS OFFICE OF ANY CHANGES IN HEALTH COVERAGE WITHIN 31 DAYS OF EVENT****

ENROLLED IN MEDICARE? ☐ NO ☐ YES **PART A** EFFECTIVE DATE _____ **PART B** EFFECTIVE DATE _____

## 3. LIFE EVENTS

**LIFE EVENT: Select one and provide the indicated documents**

☐ Newborn (copy of Birth Certificate)
☐ Marriage (copy of Marriage Certificate)
☐ Death (copy of Death Certificate)
☐ Other Coverage or Loss of Coverage (Verification of new/loss of coverage is required) If new coverage, who is it through: _____
☐ Domestic Partnership (copy of Domestic Partner Certificate)
☐ Divorce (copy of Decree)
☐ Termination of Domestic Partnership (copy of Decree)

## 4. FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:
**BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES / SS# COPY**

| FIRST NAME | LAST NAME | GENDER | AGE | BIRTHDATE | SOCIAL SECURITY # |
|---|---|---|---|---|---|
| ☐ DOMESTIC PARTNER ☐ SPOUSE | | ☐ F ☐ M | | | |
| ☐ SON ☐ DAUGHTER | | ☐ F ☐ M | | | |
| ☐ SON ☐ DAUGHTER | | ☐ F ☐ M | | | |
| ☐ SON ☐ DAUGHTER | | ☐ F ☐ M | | | |
| ☐ SON ☐ DAUGHTER | | ☐ F ☐ M | | | |
| ☐ SON ☐ DAUGHTER | | ☐ F ☐ M | | | |

## 5. CHANGES TO EXISTING BENEFITS

| | ADD | DELETE | ADD/ DELETE WHOM | PLAN CHANGES |
|---|---|---|---|---|
| **HEALTH** | ☐ | ☐ | ☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family | ☐ No Change to Medical Plan<br>☐ Change to Medical Option A<br>☐ Change to Medical Option B<br>☐ Change to Medical Option C |
| **DENTAL** | ☐ | ☐ | ☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family | ☐ No Change to Dental Plan<br>☐ Change to Delta Dental<br>☐ Change to PUD |
| **VISION** | ☐ | ☐ | ☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family | ☐ No Change to Vision Plan<br>☐ Change to MES (Plan A & B ONLY)<br>☐ Change to Kaiser Vision (Kaiser Members ONLY) |
| **DEPENDENT LIFE** | ☐ | ☐ | ☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family | |

*The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.

**EMPLOYEE SIGNATURE**_____ **DATE** _____

| Verified by: | Effective Date: |
|---|---|
| | |

# California Region Group Enrollment/Change Form

**Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.**

| Company name FRESNO UNIFIED SCHOOL DISTRICT | | Hire date (mm/dd/yyyy) |
|---|---|---|
| Group number 603815 | Enrollment unit: 0000 | Effective enrollment/ change date: |

**A. ENROLLMENT/CHANGE REASON** (see Change Table for assistance) New group: ☐ Yes ☒ No

☐ New Hire (complete sections A, B, C, D) ☐ Open Enrollment (complete sections A, B, C, D)

☒ Other Reason (complete sections A, B, C, D): _____

Health Plan (Check one) ☐ HMO Plan ☒ Deductible Plan ☐ Other:

**B. EMPLOYEE**: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known) | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) Gender ☐ M ☐ F

Home Address | City | State | ZIP

Work Phone | Home Phone | Email

Ethnicity | Preferred Language

**C. FAMILY:** For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

| | | |
|---|---|---|
| ☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner<br>Spouse/domestic partner name:<br>Former last name (if any): | Gender ☐ M ☐ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ☐ Add ☐ Delete ☐ Child<br>Dependent name:<br>Relationship: | Gender ☐ M ☐ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ☐ Add ☐ Delete ☐ Child<br>Dependent name:<br>Relationship: | Gender ☐ M ☐ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

**D. Kaiser Foundation Health Plan, Inc., 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 all Kaiser Permanente Plans** **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages 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.*

KAISER PERMANENTE®