



CALIFORNIA SCHOOLS
VEBA

Enrollment Form

Kaiser Permanente, UnitedHealthcare, SIMNSA

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, UnitedHealthcare or SIMNSA.

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 and SIMNSA 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 & IRS Section 125 Election

- Employees enrolling in a UHC Plan must review and sign the "Release of Medical Information" section
- Employees must choose pre-tax or post tax deduction of co-premiums

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:	
Last Name:	First Name:	MI:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Mailing Address:		City:	State: Zip Code:
Home Telephone:		Work Telephone:	Birth Date (mm-dd-yy):
Social Security No. (SSN):	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Domestic Partner		
PCP Name (UHC Members):	PCP Number (UHC Members):	Are You an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently on COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," COBRA Qualifying Event & Effective Date _____		Your Email Address:	

D. Employer to Complete This Section

Group #
Requested Effective Date:
CVEA CVAA CSEA CVSA <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Peoplesoft <input type="checkbox"/> Benefits Database <input type="checkbox"/> Retiree/COBRA Coupons <input type="checkbox"/> Sent to Vendor
<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA

B. Select Your Coverage

Enrollees	Health Plan	OPEN ENROLLMENT	NEW HIRE	QUALIFYING EVENT – Describe
<input type="checkbox"/> Self <input type="checkbox"/> Self + 1 <input type="checkbox"/> Self + family	<input type="checkbox"/> Kaiser Permanente HMO	UnitedHealthcare (UHC) PHMO <input type="checkbox"/> Network 1 <input type="checkbox"/> Network 2	UHC Alliance HMO <input type="checkbox"/> Alliance \$1200 <input type="checkbox"/> Alliance 20/30	<input type="checkbox"/> UHC PPO Nexus ACO 80/50 UHC Journey <input type="checkbox"/> Harmony <input type="checkbox"/> Alliance <input type="checkbox"/> SIMNSA HMO

C. Dependent Information (attach additional sheets if necessary)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Spouse/Domestic Partner Name	<input type="checkbox"/> M <input type="checkbox"/> F	Address (if different from yours)	Birth Date (mm-dd-yy)	SSN:	PCP Name: _____ PCP No.: _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent Name (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Address (if different from yours)	Birth Date (mm-dd-yy)	SSN:	PCP Name: _____ PCP No.: _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent Name (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Address (if different from yours)	Birth Date (mm-dd-yy)	SSN:	PCP Name: _____ PCP No.: _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent Name (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Address (if different from yours)	Birth Date (mm-dd-yy)	SSN:	PCP Name: _____ PCP No.: _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change	Dependent Name (Last, First, MI)	<input type="checkbox"/> M <input type="checkbox"/> F	Address (if different from yours)	Birth Date (mm-dd-yy)	SSN:	PCP Name: _____ PCP No.: _____ Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

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 arbitration¹) 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 arising under this Agreement. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered in California under this contract were unnecessary 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. For more information, please refer to your 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

Employee Name (please print)

Date (month/day/year)

