

# SHASTA-TRINITY SCHOOLS INSURANCE GROUP GROUP ENROLLMENT/CHANGE FORM

EFFECTIVE DATE				

I. EMPLOYEE INFORMATION						
LAST NAME (Print)		FIRST NAME (Print)		M.I.	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DOMESTIC PARTNERSHIP
ADDRESS/NEW ADDRESS (If changed):			CITY	STATE	ZIP	
SOCIAL SECURITY #	DISTRICT	DATE HIRE/REHIRED DATE MO DAY YR	JOB TITLE	DEPT #	PHONE #	

II. TYPE OF ACTION REQUESTED:					
<input type="checkbox"/> <b>NEW ENROLLMENT:</b> <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME			<input type="checkbox"/> <b>RETIREMENT:</b> DATE _____ <input type="checkbox"/> <b>COBRA</b>		
<input type="checkbox"/> <b>CHANGE IN STATUS:</b> <input type="checkbox"/> ADD SPOUSE/DOMESTIC PARTNER - EFF. DATE _____			<input type="checkbox"/> REMOVE SPOUSE/DOMESTIC PARTNER - EFF. DATE _____		
<input type="checkbox"/> OPEN ENROLLMENT CHANGE		<input type="checkbox"/> CHANGE OF ADDRESS		<input type="checkbox"/> NAME CHANGE: _____	
<input type="checkbox"/> ADD FAMILY MEMBER(s) - EFFECTIVE DATE/REASON _____			<input type="checkbox"/> REMOVE FAMILY MEMBER(s) - EFFECTIVE DATE/REASON _____		
<input type="checkbox"/> MEDICAL PLAN: <input type="checkbox"/> C <input type="checkbox"/> C-2		<input type="checkbox"/> DELTA DENTAL		<input type="checkbox"/> VISION SERVICE PLAN	
<input type="checkbox"/> <b>COBRA ELECTION:</b>		<input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			
GROUP NO: _____	GROUP NO: 2774-	GROUP NO: 00795001-			

**III. EMPLOYEE & FAMILY INFORMATION** Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary.)  
**PRIOR COVERAGE INFORMATION:** Please complete the area "Has Other Health Plan" in order to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you or your eligible members were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law, your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate. REASON FOR ENDING COVERAGE:

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	Qualifies as IRS Dependent	Full-Time Student	DATE OF BIRTH	AGE	TOTALLY DISABLED	HAS OTHER HEALTH PLAN?	COVERAGE BEGIN DATE	COVERAGE END DATE	CARRIER NAME
SELF							MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
SPOUSE/DOMESTIC PARTNER							MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Son					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Daughter					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Son					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Daughter					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Son					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Daughter					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	MO DAY YR		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO			

Are you retired? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, do you have Medicare?..... Part A <input type="checkbox"/> YES <input type="checkbox"/> NO Part B <input type="checkbox"/> YES <input type="checkbox"/> NO Is your Spouse/Domestic Partner retired? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, does your Spouse/Domestic Partner have Medicare? ..... Part A <input type="checkbox"/> YES <input type="checkbox"/> NO Part B <input type="checkbox"/> YES <input type="checkbox"/> NO Name(s) of Medicare Dependent(s): _____ _____	If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s). HIB# _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____ HIB# _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____ HIB# _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____ HIB# _____ Entitlement Reason: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD Effective Date of Medicare ____/____/____ Name _____
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IV. COBRA INFORMATION - To be completed by employer			
District Name _____  Check correct box indicating "Qualifying Event" causing loss of coverage <b>EMPLOYEE:</b> <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction of employee's work hours <input type="checkbox"/> Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees.	<b>FAMILY MEMBER:</b> <input type="checkbox"/> Death of the employee <input type="checkbox"/> Divorce or legal separation from employee <input type="checkbox"/> Loss of dependent child eligibility <input type="checkbox"/> Employee's entitlement to Medicare <input type="checkbox"/> Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees.	<input type="checkbox"/> <b>OTHER:</b> If enrolling from a prior carrier's COBRA coverage please indicate the qualifying event date and coverage date below.  Date of Qualifying Event _____ Date of Loss of Coverage _____  Date When Continued Coverage Ends _____ Date Notice Given _____ Applicant's Init. _____  Group Policyholder Rep. Signature _____ Telephone No. _____	

**PLEASE READ CAREFULLY**

V. DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.  
 VI. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.  
**Applicant must initial and date this medical information authorization.** Initial & Date \_\_\_\_\_

VII. HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.  
 VIII. EFFECTIVE DATE: The effective date of coverage is subject to Blue Cross of California approval.

IX. AUTHORIZATION IN CONJUNCTION WITH COORDINATION OF BENEFITS WITH MEDICARE: I hereby authorize the U.S. Dept. of Health and Human Services (including the Healthcare Financing Administration and any other contractors or agents including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Anthem Blue Cross any and all records pertaining to claims submitted, payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Anthem Blue Cross to process claims. A photocopy of this authorization shall be as valid as the original.  
 Initial & Date \_\_\_\_\_

X. ARBITRATION AGREEMENTS: I understand that any and all disputes between myself (and/or any enrolled family member) and Anthem Blue Cross/Life & Health Insurance Co., or the JPA, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Clams Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Anthem Blue Cross/Life & Health Insurance Co. are giving up the right to have any dispute decided in a court of law before a jury. Anthem Blue Cross/Life & Health Insurance Co. and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

XI. SIGNATURE OF UNDERSTANDING (Applicant must initial and date Section IX. Release of Medical Information)  
 I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files.  
**BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

_____ <b>Employee Signature</b>	_____ <b>Date</b>
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