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

EFFECTIVE DATE

I. EMPLOYEE INFORMATION

LAST NAME (Print)	FIRST NAME (Print)	M.I.	☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNERSHIP
ADDRESS/NEW ADDRESS (If changed):	CITY	STATE	ZIP	
SOCIAL SECURITY # / DISTRICT	DATE HIRE/REHIRED DATE MO DAY YR / JOB TITLE	CLASS #	PHONE #	

II. TYPE OF ACTION REQUESTED:

☐ **NEW ENROLLMENT:** ☐ FULL-TIME ☐ PART-TIME ☐ **CHANGE OF ADDRESS** ☐ **RETIREMENT:** DATE _____ ☐ **CAL-COBRA** ☐ **COBRA**

☐ **CHANGE IN STATUS:** ☐ ADD SPOUSE/DOMESTIC PARTNER – EFF. DATE _____ ☐ REMOVE SPOUSE/DOMESTIC PARTNER – EFF. DATE _____

☐ OPEN ENROLLMENT CHANGE ☐ NAME CHANGE: _____

☐ ADD FAMILY MEMBER(s) – EFFECTIVE DATE/REASON _____ ☐ REMOVE FAMILY MEMBER(s) – EFFECTIVE DATE/ REASON _____

☐ MEDICAL ☐ ACTIVE ☐ RET. < 65 ☐ TIERED ☐ RET. > 65 ☐ C ☐ C-2 ☐ COMPOSITE GROUP NO: _____	☐ DELTA DENTAL GROUP NO: _____	☐ VISION SERVICE PLAN GROUP NO: _____	☐ **COBRA ELECTION:** ☐ MEDICAL ☐ DENTAL ☐ VISION

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		☐ YES ☐ NO	☐ YES ☐ NO			
SPOUSE/ DOMESTIC PARTNER							MO DAY YR		☐ YES ☐ NO	☐ YES ☐ NO			
☐ Son ☐ Daughter					☐ YES ☐ NO	☐ YES ☐ NO	MO DAY YR		☐ YES ☐ NO	☐ YES ☐ NO			
☐ Son ☐ Daughter					☐ YES ☐ NO	☐ YES ☐ NO	MO DAY YR		☐ YES ☐ NO	☐ YES ☐ NO			
☐ Son ☐ Daughter					☐ YES ☐ NO	☐ YES ☐ NO	MO DAY YR		☐ YES ☐ NO	☐ YES ☐ NO			
☐ Son ☐ Daughter					☐ YES ☐ NO	☐ YES ☐ NO	MO DAY YR		☐ YES ☐ NO	☐ YES ☐ NO			

Are you retired? ☐ YES ☐ NO

If yes, do you have Medicare? Part A ☐ YES ☐ NO

Part B ☐ YES ☐ NO

Is your Spouse/Domestic Partner retired? ☐ YES ☐ NO

If yes, does your Spouse/Domestic Partner have Medicare? Part A ☐ YES ☐ NO

Part B ☐ YES ☐ 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: ☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare ____/____/____ Name _____

HIB# _____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare ____/____/____ Name _____

HIB# _____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare ____/____/____ Name _____

HIB# _____ Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare ____/____/____ Name _____

IV. COBRA INFORMATION – To be completed by employer

Company Name _____

Check correct box indicating "Qualifying Event" causing loss of coverage

EMPLOYEE:

- ☐ Termination of employment
- ☐ Reduction of employee's work hours
- ☐ 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.

FAMILY MEMBER:

- ☐ Death of the employee
- ☐ Divorce or legal separation from employee
- ☐ Loss of dependent child eligibility
- ☐ Employee's entitlement to Medicare
- ☐ 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.

☐ **OTHER:** 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 Anthem Blue Cross approval.

IX. AUTHORIZATION TO RELEASE INFORMATION IN CONJUNCTION WITH COORDINATION OF BENEFITS WITH MEDICARE: I hereby authorize the U.S. Department of Health and Human Services (including the Healthcare Financing Administration and any 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.

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 foe 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 thew 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.

X. 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.

X _____

Employee Signature **Date**

Anthem Blue Cross is an Independent Licensee of the Blue Cross Association.

DISTRIBUTION: WHITE – Shasta-Trinity SIG - 6724 Lockheed Dr., Suite 3A, Redding, CA 96002; Phone: (530) 221-6444 Fax: (530) 221-6225 CANARY – Employer PINK – Employee