

STSIG ENROLLMENT FORM - Type or print clearly in black ink Revised 10/2018

SECTION I: SELECTED COVERAGE

ENROLLMENT REASON: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> EMPLOYEE STATUS CHANGE TO <input type="checkbox"/> RETIREE <65 <input type="checkbox"/> RETIREE >65 <input type="checkbox"/> COBRA							
JOB TITLE: _____		EFFECTIVE DATE: _____		HIRE DATE: _____		DISTRICT APPROVED INITIALS: _____	
DISTRICT NAME (DO NOT ABBREVIATE)		EMPLOYEE GROUP (BARGAINING UNIT)				<input type="checkbox"/> Full-time	
		<input type="checkbox"/> Certificated <input type="checkbox"/> Classified <input type="checkbox"/> Management <input type="checkbox"/> Confidential <input type="checkbox"/> Active <input type="checkbox"/> Admin <input type="checkbox"/> Board Member				<input type="checkbox"/> Part-time	
This row to be completed by STSIG only		Medical Group Number		Dental Group Number		Vision Group Number	
				2774-		2550-	

SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED

<input type="checkbox"/> MEDICAL <input type="checkbox"/> Decline <input type="checkbox"/> DENTAL <input type="checkbox"/> Decline <input type="checkbox"/> VISION <input type="checkbox"/> Decline	SOCIAL SECURITY NO.		LAST NAME (PRINT)		FIRST NAME (PRINT)		MI	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	MAILING ADDRESS					CITY		STATE	ZIP
	TELEPHONE NO. ()		E-MAIL ADDRESS			DO YOU HAVE MEDICARE A&B COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, attached copy of card		Medicare Number:	

MEDICAL PLAN OPTIONS – CHOOSE ONE

80C 80G 80K 80M HSA-A HSA-B HSA - Min.Value Decline

Dental Plan

SECTION III: DEPENDENT INFORMATION

<input type="checkbox"/> MEDICAL <input type="checkbox"/> Decline <input type="checkbox"/> DENTAL <input type="checkbox"/> Decline <input type="checkbox"/> VISION <input type="checkbox"/> Decline	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		LAST NAME (PRINT)		FIRST NAME (PRINT)		MI	SOCIAL SECURITY NO.	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE MEDICARE A&B COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO:		Medicare Number:		Attach copy of Medicare Card	

<input type="checkbox"/> MEDICAL <input type="checkbox"/> Decline <input type="checkbox"/> DENTAL <input type="checkbox"/> Decline <input type="checkbox"/> VISION <input type="checkbox"/> Decline	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		LAST NAME (PRINT)		FIRST NAME (PRINT)		MI	SOCIAL SECURITY NO.	
		DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO						

<input type="checkbox"/> MEDICAL <input type="checkbox"/> Decline <input type="checkbox"/> DENTAL <input type="checkbox"/> Decline <input type="checkbox"/> VISION <input type="checkbox"/> Decline	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		LAST NAME (PRINT)		FIRST NAME (PRINT)		MI	SOCIAL SECURITY NO.	
		DATE OF BIRTH	TOTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO						

**** Dependent enrollments require proof of dependence – please attached proof with enrollment form.**

- I understand it is my responsibility to notify my district once a dependent is no longer eligible due to divorce or over age children. If I fail to report loss of eligibility I may be financially liable to STSIG if claims were paid on behalf of non-eligible individuals.
- **DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution. Pre-tax After-tax
- **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- **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.
- **EFFECTIVE DATE:** The effective date of coverage is subject to STSIG III approval.
- Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

SECTION IV: SIGNATURE OF UNDERSTANDING – APPLICANT MUST SIGN

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. Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, STSIG, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. 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.

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND STSIG AND/OR SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS 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 STSIG AND/OR SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. STSIG AND/OR SISC III 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 BOOKLET.)

Applicant Signature Required Date

