STSIG ENROLLMENT FORM - Type or print clearly in black ink Revised 10/2023

SECTION I: SELECTED COVERAGE

ENROLLMENT REASON: ☐ **NEW HIRE** ☐ **EMPLOYEE STATUS CHANGE TO** ☐ **RETIREE <65** ☐**RETIREE >65**

JOB TITLE: _____ EFFECTIVE DATE: _____ HIRE DATE: _____DISTRICT APPROVEDINITIALS: _____

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGANING UNIT) ☐Certificated ☐Classified ☐Management ☐Confidential ☐Active ☐Admin ☐Board Member	☐Full-time ☐Part-time

This row to be completed by STSIG only	Medical Group Number	Dental Group Number 2774-	Vision Group Number 2550-

SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED

☐ **MEDICAL** ☐ **Decline** ☐ **DENTAL** ☐ **Decline** ☐ **VISION** ☐ **Decline**

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	DATE OF BIRTH	☐ MALE ☐ FEMALE
MAILING ADDRESS		CITY	STATE	ZIP	
TELEPHONE NO. ( )	E-MAIL ADDRESS -Required	DO YOU HAVE MEDICARE A&B COVERAGE? ☐ YES ☐ NO If yes, attached copy of card	Medicare Number:		

MEDICAL PLAN OPTIONS – CHOOSE ONE

☐80C ☐80G ☐80K ☐80M ☐HSA-$1500 ☐HSA-$3000 ☐ HSA-$5000 ☐Decline

Dental Plan Choice

SECTION III: DEPENDENT INFORMATION

☐ **MEDICAL** ☐ **Decline** ☐ **DENTAL** ☐ **Decline** ☐ **VISION** ☐ **Decline**

☐**Spouse** ☐**Domestic Partner**	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
Gender ☐ Male ☐ Female	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	DO YOU HAVE MEDICARE A&B COVERAGE? ☐ YES ☐ NO:	Medicare Number:	Attach copy of Medicare Card

☐ **MEDICAL** ☐ **Decline** ☐ **DENTAL** ☐ **Decline** ☐ **VISION** ☐ **Decline**

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO		

☐ **MEDICAL** ☐ **Decline** ☐ **DENTAL** ☐ **Decline** ☐ **VISION** ☐ **Decline**

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NO.
	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	**District Information: Completed by the District** EE ID #_____ Monthly ER Contribution Amount $_____ Retirement Date _____ Contract Group Name _____Contract Expiration Date _____	

**** Dependent enrollments require proof of dependence – please attach proof with the 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 THE COVERAGE BOOKLET.)

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Applicant Signature Required Date