



Benefits Enrollment/Change Form



The San Diego Unified School District belongs to the California Schools Voluntary Employee Benefits Association (CA Schools VEBA). Since 1993, CA Schools VEBA has been providing management of Southern California's largest federally-funded trust that specializes in providing health care benefits for education employees and eligible district retirees. The District and CA Schools VEBA are committed to helping you and your family be healthy and stay healthy. To make sure that your health plan selections will best meet the needs of you and your family, we encourage you to review the benefit summaries for each plan which are available on the district website at sandiegounified.org/benefits.

PLEASE NOTE: If it is the Open Enrollment period and you are only making a plan change, please access Open Enrollment online under the Benefits folder in PeopleSoft Self-Service. No form will be necessary and a confirmation email will be sent automatically after your selections are confirmed.

New Enrollment Checklist:

- Step 1:** Visit sandiegounified.org/benefits to review plan information and decide on coverage. Additional information about benefits and other resources can be found online in the Employee Benefits Information Guide for active employees.
- Step 2:** If enrolling in a United Healthcare (UHC) HMO medical plan, Delta Dental HMO (DeltaCare USA) or Western Dental HMO, please select a primary care provider (PCP) and/or dental provider by searching on the carrier website or calling the carrier directly:
 - United Healthcare: welcometouhc.com/csveba or (888) 586-6365
 - DeltaCare USA: deltadentalins.com or (800) 422-4234
 - Western Dental: westerndental.com or (800) 992-3366
- Step 3:** Gather the personal information for each enrollee (i.e. address, social security number and birthdate). Documentation to establish proof of eligibility is required for each dependent. A list of acceptable supporting documentation can be found on the Employee Benefits Department webpage.
- Step 4:** Complete the attached form in full making sure to provide signatures on the back pages under the carrier language for each medical and/or dental plan selected.
- Step 5:** Return the completed form and all supporting documents to the San Diego Unified Employee Benefits Department within 31 days of becoming eligible for coverage or before the end of the Open Enrollment period if making changes during Open Enrollment. Documents may be sent using any method below:
 - Scan and email to employeebenefits@sandi.net
 - Fax to (619) 725-8132
 - Mail or drop off in person:
Employee Benefits Department
San Diego Unified School District
4100 Normal Street, Room 1150A
San Diego, CA 92103

Questions? Please reach out to us at (619) 725-8130 or employeebenefits@sandi.net. We would be happy to help!

REASON FOR THIS APPLICATION:

- OPEN ENROLLMENT
- NEW HIRE _____ (DATE OF HIRE)
- REHIRE/RETURN FROM LEAVE _____ (DATE OF HIRE)

- ADD DEPENDENT: MARRIAGE
_____ (DATE OF MARRIAGE)

- ADD DEPENDENT: BIRTH/ ADOPTION
_____ (DATE OF BIRTH/ ADOPTION)

- ADD DEPENDENT: OTHER QUALIFYING EVENT

- ADDRESS CHANGE
- NAME CHANGE
- DELETE DEPENDENT
- QMCSO
- COBRA

- EMPLOYER USE ONLY:**
EFFECTIVE DATE: _____
- DISTRICT ID #: _____
- ACTIVE
 - RETIRED
 - LOA
 - COBRA

INDICATE YOUR PLAN SELECTION BELOW:

MEDICAL PLAN:

- KAISER HMO
- UNITEDHEALTHCARE PERFORMANCE HMO NETWORK 1
- UNITEDHEALTHCARE PERFORMANCE HMO NETWORK 2
- UNITEDHEALTHCARE SIGNATUREVALUE ALLIANCE HMO
- UNITEDHEALTHCARE SELECT PLUS PPO

DENTAL PLAN:

- DELTA DENTAL HMO
(DELTACARE USA)
- DELTA DENTAL PPO
- WESTERN DENTAL

VISION PLAN:

- VSP VISION

EMPLOYEE INFORMATION:

EMPLOYEE NAME: _____ MALE
 FEMALE

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____ BIRTH DATE (MM/DD/YY): _____

SOCIAL SECURITY NUMBER (SSN): _____ MARITAL STATUS: SINGLE MARRIED DOMESTIC PARTNER

EMAIL ADDRESS: _____

EMPLOYEE INFORMATION CONTINUED:

MEDICAL PRIMARY CARE PHYSICIAN - FIRST AND LAST NAME <i>(UNITEDHEALTHCARE HMO PLANS ONLY)</i> :	EXISTING PATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
DENTAL PROVIDER NAME OR ID# <i>(DELTACARE USA HMO PLAN ONLY)</i> :	EXISTING PATIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO

***WHEN A PROVIDER IS NOT SELECTED ON A HMO PLAN, THE CARRIER WILL SELECT ONE FOR YOU AND YOUR ELIGIBLE DEPENDENTS.**

DEPENDENT INFORMATION:

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YY)	SEX M/F	MEDICAL COVERAGE (CHECK IF YES)	FIRST AND LAST NAME OF PCP (UHC HMO ONLY)	EXISTING PATIENT (CHECK IF YES)	DENTAL COVERAGE	DENTAL PROVIDER NAME OR ID# (HMO ONLY)	EXISTING PATIENT (CHECK IF YES)	VISION COVERAGE (CHECK IF YES)
SPOUSE/DOMESTIC PARTNER				<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
CHILD				<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
CHILD				<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
CHILD				<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE
CHILD				<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE		<input type="checkbox"/>	<input type="checkbox"/> ADD <input type="checkbox"/> DELETE

IF ANY DEPENDENTS LISTED ABOVE HAVE AN ADDRESS THAT IS DIFFERENT FROM THE EMPLOYEE, PLEASE LIST BELOW:

NAMES AND CORRESPONDING ADDRESS:

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EMPLOYEE SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES

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 **Delta Dental Plan**
- Sign **D** below for **Western Dental 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 arbitration 1) 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 Required for UnitedHealthcare Plan

Employee Name (please print)

Date (month/day/year)

SECTION B CONTINUED (UHC PLAN MEMBERS MUST SIGN "AUTHORIZATION TO RELEASE MEDICAL INFORMATION" BELOW)

HIV Disclaimer

"California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage."

Legal Entities Disclaimer

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by UnitedHealthcare Insurance Company, United HeathCare Services, Inc., PacifiCare Health Plan Administrators, Inc., Prescription Solutions or Optum Health Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Authorization to Release Medical Information

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefits records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care providers, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearing house, and any of their affiliates, representatives or business associates who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and affiliates to make decisions regarding eligibility, enrollment and risk rating. I understand this authorization is voluntary and I may refuse to sign authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person to obtain and use may be redisclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request that indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize the required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

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 UnitedHealthcare Plan

Employee Name (please print)

Date (month/day/year)

EMPLOYEE SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES

C: Delta Dental Plan Binding Arbitration Agreement (*Read and sign this section ONLY if you enroll in a Delta Dental Plan*) **Delta Dental Plan Arbitration Agreement**

I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract. In addition, I agree to the following authorizations:

- I Deduction Authorization: I hereby authorize San Diego Unified School District to pay the dental benefits premiums for me and my eligible dependents (if applicable) to the plan checked above until changed or revoked by me in writing. I also authorize San Diego Unified School District to deduct from my salary the amount necessary, if any, to pay for my dental coverage not paid by the district and to transmit the same to the above-named plan.
 - II Authorization to Obtain or Release Medical Information (Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et.seq. of the California Civil Code): I hereby authorize my dentist, physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of the dental plan in which I am enrolling as indicated above, any and all records pertaining to medical/dental history, services rendered or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize such carriers or their agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical/dental information obtained, if such disclosure is necessary, to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to allow the processing of any claim.
 - III Arbitration Agreement: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled eligible dependent) and Delta Dental PPO Plan or Delta Care USA Dental whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.
 - IV Dependent Coverage: I have read and understand the provisions on this form pertaining to dependents who are eligible to be included in my dental coverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listed on this enrollment form may be added only by submitting appropriate forms to the Employee Benefits Department within 31 days of the date the dependent becomes eligible for coverage or during the annual Open Enrollment period held in the fall.
- 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 Delta Dental Plan

Employee Name (please print)

Date (month/day/year)

EMPLOYEE SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES

D: Western Dental Plan Binding Arbitration Agreement (Read and sign this section ONLY if you enroll in a Western Dental Plan)
Western Dental Plan Arbitration Agreement

- I Deduction Authorization: I hereby authorize San Diego Unified School District to pay the dental benefits premiums for me and my eligible dependents (if applicable) to the plan checked above until changed or revoked by me in writing. I also authorize San Diego Unified School District to deduct from my salary the amount necessary, if any, to pay for my dental coverage not paid by the district and to transmit the same to the above-named plan.
 - II Authorization to Obtain or Release Medical Information (Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et.seq. of the California Civil Code): I hereby authorize my dentist, physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of the dental plan in which I am enrolling as indicated above, any and all records pertaining to medical/dental history, services rendered or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize such carriers or their agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical/dental information obtained, if such disclosure is necessary, to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to allow the processing of any claim.
 - III Arbitration Agreement: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled eligible dependent) and Western Dental whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.
 - IV Dependent Coverage: I have read and understand the provisions on this form pertaining to dependents who are eligible to be included in my dental coverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listed on this enrollment form may be added only by submitting appropriate forms to the Employee Benefits Department within 31 days of the date the dependent becomes eligible for coverage or during the annual Open Enrollment period held in the fall.
 - V I agree and understand that any and all disputes, including claims of dental malpractice (that is as to whether any dental services rendered under the dental health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) between myself (including any heirs or assigns) and Western Dental Services, Inc., shall be determined by submission to arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Both 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.
- 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 Western Dental Plan

Employee Name (please print)

Date (month/day/year)