Benefits Enrollment/Change Form

Rev 1/2024

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 **sandiegounifed.org/departments/benefits**.

New Enrollment Checklist:

☐ **Step 1:** Visit **sandiegounified.org/departments/benefits** to review plan information and decide on coverage.

☐ **Step 2:** Select a primary care provider (PCP) and/or dental provider if enrolling on an HMO plan. Search for providers on the carrier website or by phone:

UnitedHealthcare: **whyuhc.com/csveba** or (888) 586-6365
DeltaCare USA: **deltadentalins.com** or (800) 422-4234
Western Dental: **westerndentalbenefits.com** or (800) 992-3366

☐ **Step 3:** Documentation to establish proof of eligibility is required for each dependent. A list of Dependent Eligibility Verification Requirements 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. No signature is required for vision plan enrollment.

☐ **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!

EMPLOYEE INFORMATION:

SOCIAL SECURITY NUMBER *(SSN)*:	EMPLOYEE NAME: *(First, MI, Last)*	DISTRICT ID#:
☐ MALE ☐ FEMALE ☐ NON-BINARY	BIRTH DATE *(MM/DD/YY)*:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER
MAILING ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE: ☐ HOME ☐ MOBILE	WORK TELEPHONE:	
EMAIL ADDRESS:		

INDICATE YOUR PLAN SELECTION BELOW:

MEDICAL PLAN:	**DENTAL PLAN:**	**VISION PLAN:**
☐ KAISER HMO	☐ DELTA DENTAL HMO (DELTACARE USA)	☐ VSP VISION
☐ UNITEDHEALTHCARE PERFORMANCE HMO NETWORK 1	☐ DELTA DENTAL PPO	
☐ UNITEDHEALTHCARE CS VEBA ALLIANCE $20	☐ WESTERN DENTAL	
☐ UNITEDHEALTHCARE PERFORMANCE HMO NETWORK 3		
☐ UNITEDHEALTHCARE JOURNEY ALLIANCE HMO		
☐ UNITEDHEALTHCARE JOURNEY HARMONY HMO		
☐ UMR NEXUSACO PPO		

REASON FOR THIS APPLICATION:

☐ OPEN ENROLLMENT	EFFECTIVE DATE: _____
☐ NEW HIRE _____ (DATE OF HIRE)	DISTRICT ID #: _____
☐ OTHER CHANGE: PLEASE DESCRIBE	☐ ACTIVE
_____	☐ RETIRED
_____	☐ LOA
_____	☐ COBRA

EMPLOYEE PHYSICIAN INFORMATION:

MEDICAL PRIMARY CARE PHYSICIAN - FIRST AND LAST NAME *(UHC HMO plans ONLY)*:	EXISTING PATIENT: ☐ YES ☐ NO
DENTAL PROVIDER NAME OR FACILITY ID# *(DELTACARE USA HMO PLAN ONLY)*:	EXISTING PATIENT: ☐ YES ☐ NO

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

DEPENDENT INFORMATION:

Social Security Number	NAME (First, MI, Last)	DATE OF BIRTH (MM/DD/YY)	SEX M/F/NB	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 FACILITY ID# (HMO ONLY)	VISION COVERAGE (CHECK IF YES)
	SPOUSE/DOMESTIC PARTNER			☐ ADD ☐ DELETE ☐ CHANGE*	PCP ID:	☐ YES	☐ ADD ☐ DELETE ☐ CHANGE*		☐ ADD ☐ DELETE ☐ CHANGE*
	CHILD			☐ ADD ☐ DELETE ☐ CHANGE*	PCP ID:	☐ YES	☐ ADD ☐ DELETE ☐ CHANGE*		☐ ADD ☐ DELETE ☐ CHANGE*
	CHILD			☐ ADD ☐ DELETE ☐ CHANGE*	PCP ID:	☐ YES	☐ ADD ☐ DELETE ☐ CHANGE*		☐ ADD ☐ DELETE ☐ CHANGE*
	CHILD			☐ ADD ☐ DELETE ☐ CHANGE*	PCP ID:	☐ YES	☐ ADD ☐ DELETE ☐ CHANGE*		☐ ADD ☐ DELETE ☐ CHANGE*
	CHILD			☐ ADD ☐ DELETE ☐ CHANGE*	PCP ID:	☐ YES	☐ ADD ☐ DELETE ☐ CHANGE*		☐ ADD ☐ DELETE ☐ CHANGE*

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

NAMES AND CORRESPONDING ADDRESS:

IF ANY DEPENDENTS ARE ALSO COVERED BY ANOTHER SAN DIEGO UNIFIED DISTRICT EMPLOYEE, PLEASE LIST NAME OF EMPLOYEE AND DISTRICT ID# (IF KNOWN)

EMPLOYEE SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES (NO SIGNATURE REQUIRED FOR VISION PLAN)

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** on Page 4 for **UnitedHealthcare/UMR Plans**
- Sign **C** on Page 5 for **Delta Dental Plan**
- Sign **D** on Page 6 for **Western Dental Plan**

SECTION 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.*

SECTION B: UnitedHealthcare/UMR Plan Members Binding Arbitration Agreement

(Read and sign this section ONLY if you enroll in a UnitedHealthcare/UMR 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.

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/UMR Plan	**Employee Name** (please print)	**Date** (month/day/year)

EMPLOYEE SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES (NO SIGNATURE REQUIRED FOR VISION PLAN)

Section 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 (ifapplicable) 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. ofthe 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 agreementbetween 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 (NO SIGNATURE REQUIRED FOR VISION PLAN)

Section 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. ofthe 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 dentalcoverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listedon 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 thedental 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)