SIG ENROLLMENT / CHANGE FORM

District Name	Dept. #	Effective Date	Date of Hire
Nevada County Superintendent of Schools	14	07/01/2017	

I. ENROLLMENT INFORMATION

☐ New Enrollment ☒ Open Enrollment ☐ Add Dependent ☐ Termination
☐ Status Change ☐ Retirement ☐ Delete Dependent ☐ Deceased
☐ Loss of Coverage (provide HIPAA Cert) ☐ Name Change ☐ Address Change

Event: Event Date:

II. PLAN CHOICES

Medical (Actives/Retirees under 65) **Group #**_____

☐ UnitedHealthcare HD PPO 2600/4500* ☐ UnitedHealthcare SignatureValue HMO
☐ UnitedHealthcare HD PPO 5000/10000*
**Health Savings Account (HSA) compatible plans*

Other Coverage
☐ Delta Dental Plan
☐ Vision Service Plan
☐ Life Insurance
☐ Optum HSA

III. PERSONAL INFORMATION

1. Name (Last, First, M.I.)		2. Social Security Number - -
3. Address	City, State, Zip	4. Phone No. ( )
5. Gender ☐ Male ☒ Female	6. Date of Birth (MM/DD/YYYY) / /	7. Marital Status ☒ Single ☐ Married	8. Email Address
9. Bargaining Group	10. Monthly Payroll Frequency ☐10 ☐11 ☐12	11. ☐ Full Time ☐ Part Time (over 20 hrs)

IV. FAMILY INFORMATION

	Last Name, First Name, MI	Gender	Social Security Number	Date of Birth	☐ Add ☐ Delete
☐ Spouse ☐ Registered Domestic Partner		☒ M ☐ F	_____-____-_____	___/___/___	☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			_____-____-_____	___/___/___	☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			_____-____-_____	___/___/___	☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			_____-____-_____	___/___/___	☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			_____-____-_____	___/___/___	☐ Medical ☐ Dental ☐ Vision

Employer Section: Must be completed by District Office Benefit Coordinator- Please initial: _____

UHC HMO	UHC HD PPO	Dental Plan Code	Vision Plan Code	Life / AD&D Amount	Health Savings Acct
☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐Chg
Old Code	Old Code	Old Code	Old Code	Old Code	
_____/_____/_____ Effective Date	_____/_____/_____ Effective Date	_____/_____/_____ Effective Date	_____/_____/_____ Effective Date	_____/_____/_____ Effective Date	_____/____/_____ Effective Date

Employee Name: _____

- Do any family members have other health insurance (including Medicare)? ☐ Yes ☐ No
  If yes, please list names _____Carrier:_____
- Are any dependents (spouse and/or children) totally disabled? ☐ Yes ☐ No
  If yes, please list names _____

For UnitedHealthcare Signature Value HMO plan, please select a Primary Care Physician for each family member.					
	Name	**Physician Name**	**Medical Group**	**Current Patient? Yes or No**	**PCP#**
SELF					
☐ Spouse ☐ Domestic Partner					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

If you have a qualifying event, please notify Human Resources **within 30 days of this change**. Qualifying events include:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or child
- Spouse terminates employment or becomes employed
- Unpaid leave of absence taken by you or your spouse
- Full-time to part-time change (or vice versa)

DECLINATION OF COVERAGE

I am declining coverage for myself and /or dependents for the following plans. By declining coverage I acknowledge that my dependents and I may have to wait until the next Open Enrollment period or qualifying event:

- Medical — Declining coverage for: ☐ Spouse/DP ☐ Child(ren)
- Dental — Declining coverage for: ☐ Employee ☐ Spouse/DP ☐ Child(ren)
- Vision — Declining coverage for: ☐ Employee ☐ Spouse/DP ☐ Child(ren)

X _____ _____
Employee Signature Only if Declining Coverage **Date**

EMPLOYEE ACKNOWLEDGMENT

I request benefits under the Schools Insurance Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply or, as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct. I understand and agree that any incorrect statements material to the plan made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

To the best of my knowledge, I am an employee working the required weekly hours and I agree any information shown, including the declining coverage section**,** is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to them are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

_____ _____
Employee Signature Date

UnitedHealthcare Authorization to Release Medical Information and Signature:

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefit 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 provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, 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 this authorization is voluntary and I may refuse to sign the 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 or entity to obtain and use may be re-disclosed (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 the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any 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.

Binding Arbitration

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.

Employee Name: _____
Please Print

***Signature*:** _____ ***Date*:** _____
Required for all UnitedHealthcare Plans