Universal Enrollment/Change Form
Medical Insurance for Part-Time (Adjunct) Faculty

CHABOT LAS POSITAS COMMUNITY COLLEGE DISTRICT

Effective Date: _____ , 20 _____

SECTION 1. EMPLOYEE INFORMATION

Name (Last, First, M.I.):	Social Security Number: - -	Date of Birth: / /	Hire Date: / /
Home Address (Number, Street, Apt#):	City, State, Zip Code:		
Gender: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ Domestic Partner	Home Phone Number: ( ) -	
Email Address:	Worked For Another School District Within a Year: ☐ Yes ☐ No If yes, Where:		

SECTION 2. QUALIFYING EVENT

☐ New Enrollment - Event Date: _____
☐ Re-Hire Date _____
☐ Part-Time to Full-time Employment Date: _____
☐ Open Enrollment
☐ Change in Enrollment-Event Date: _____
☐ Family Addition - Event Date: _____
☐ Deleting Dependent(s)-Event Date: _____
☐ Terminating Coverage - Event Date: _____
☐ Other: _____ Event Date: _____

☐ Name Change* - Event Date: _____
(*Please fill in New and Previous Name below)
New Name: _____
Previous Name: _____

☐ COBRA Continuation – Qualifying event date: _____
☐ Left employment ☐ Reduction in hours ☐ Death,
☐ Divorce or legal separation ☐ Loss of dependent child status
☐ Medicare
☐ 18 months ☐ 29 months ☐ 36 months

SECTION 3. Medical Coverage Election

Proof of Eligibility Must Be Provided for All Dependents – For Spouse - Marriage Certificate or CLPCCD Domestic Partnership Affidavit or State of CA Declaration of Domestic Partnership. For child(ren) - Birth Certificate or Court Documents for Adoption/Legal Custody

☐ **Anthem Blue Cross PPO** **Group #: 1182VK**	☐ **Anthem Blue Cross HMO** **$15 co-pay Group #: 57984A**	☐ **Anthem Blue Cross HMO** **$30 co-pay Group #: 57984L**
☐ **Kaiser Permanente HMO $5 co-pay Group #: 421-0002**	☐ **Kaiser Permanente HMO $20 co-pay Group #: 421-0004**	

MEDICAL
☐ Employee Only ☐ Employee + One Dependent ☐ Family Coverage

SECTION 4. PARTICIPANT(S) INFORMATION (for more participants, use a separate piece of paper)

(**A**)dd (**C**)hange (**D**)elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth & Age	Gender	Totally Disabled	Enrolling in Anthem HMO or PPO – add Primary Care Provider ID #.	Is this your Current Doctor?
	Self		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No	ID #	☐ Yes ☐ No
	☐ Spouse ☐ Domestic Partner		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No	ID #	☐ Yes ☐ No
	Child 1		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No	ID #	☐ Yes ☐ No
	Child 2		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No	ID #	☐ Yes ☐ No
	Child 3		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No	ID # Name	☐ Yes ☐ No

Family Information:
If children are age 26 or over you must check appropriate box – IRS qualified dependent? ☐ NO ☐ YES - ☐ Child 1 ☐ Child 2 ☐ child 3
Have you included stepchildren as dependents? ☐ NO ☐ YES - If "yes" indicate name/s: _____
Do your stepchildren reside with you? ☐ NO ☐ YES
(Note: If additional space is needed, attach separate sheet of paper with the above information.)

SECTION 5. ADDITIONAL HEALTH INSURANCE INFORMATION

Do you or your dependents have other medical coverage? ☐ NO ☐ YES - If yes, please complete this section.

	Name	Name and address of other insurance Carrier	Effective Date
Self			
Spouse / Domestic Partner			
Child 1			
Child 2			
Child 3			

For Kaiser Permanente Participants Only

Are you now or have you ever been a Kaiser Permanente member? ☐ No ☐ Yes*
*If "Yes", please list your Kaiser Permanente Medical Record Number:_____

Prior Coverage for PPO Plans Only - Attach additional sheets if necessary

Please fill out the following information to receive proper credit for **previous coverage**, (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage (including MediCal or individual coverage). Note: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem.

Name (last, first, MI)	Plan Start Date	Plan End Date	Carrier Name & Phone #	Reason for Ending Coverage
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		
	/ /	/ /		

SECTION 6. Medicare Section

Are you retired?..... ☐ No ☐ Yes
If yes.....Part A ☐ No ☐ Yes
.....Part B ☐ No ☐ Yes

Do any of your dependents have Medicare?..... ☐ No ☐ Yes
If yes for your dependents.....Part A ☐ No ☐ Yes
.....Part B ☐ No ☐ Yes

If yes for Medicare for you and/or your Dependent(s), please provide the Medicare Claim Number(s) (MCN) and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

MCN # _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare _____/_____/_____
Name _____

MCN # _____
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare _____/_____/_____
Name _____

SECTION 7. Declination of Coverage (Complete this section **ONLY** if declining coverage for yourself ***OR*** eligible dependents)

	DECLINE (check all that apply *AND* give reason in right column)	**REASON**
☐	Self	☐ Have Other Group Coverage. Name of Insurance: _____
☐	Spouse / Domestic Partner	☐ Have Other Individual Coverage. Name of Insurance: _____
☐	Child(ren)	☐ Other (Explain): _____

Insurance Plan(s) you are choosing to waive (Check all that apply): ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Basic Life Ins.**

I hereby elect to decline enrollment for coverage under the CLPCCD insurance plan(s) checked above for the current year. I understand that once I have waived my rights to enroll, I will only be eligible to re-enroll during open enrollment or within 30 days after a qualifying event.

Employee's Signature for **DECLINATION** of Coverage: _____ Date:_____

COBRA Continuance: Reason: for COBRA coverage: _____

Federal COBRA qualifying event date:_____ ☐ 18 months ☐ 29 months ☐ 36 months

Anthem Blue Cross - PLEASE READ CAREFULLY – SIGNATURE REQUIRED

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.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums. **NON-PARTICIPATING PROVIDER**: I understand that I am responsible for a greater portion of my medical cost 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 Anthem Blue Cross approval. **COBRA/CAL-COBRA CONTINUATION COVERAGE**: You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing you name in the blank space below 3) paying you Total Monthly Continuation; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you received this notice.

If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1) The date eligibility for COBRA Continuation Coverage ends, or
2) The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3) The date your employer discontinues coverage with Anthem Blue Cross, or
4) The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5) The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay you initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end. **Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain right under federal law (HIPAA) to guaranteed issue individual coverage.**

W-9 Certification Language: I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE. BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY. OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICE AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy, including any disputes as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting and use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHERE ISSUES RELATED TO THE PLAN/POLICY.

_____ _____

Signature Required for Anthem Blue Cross Applicant **Date**

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.

Note: If you do not agree to the arbitration agreement above you should choose a different medical plan.

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

SECTION 8. AUTHORIZATION

Payroll Deduction Contributions

The plan administrator may reduce, adjust or cancel the amount of my payroll deduction contributions or otherwise modify this agreement if this becomes necessary to satisfy certain provisions of the Internal Revenue Code. The amount of my monthly payroll deduction contributions is shown on a schedule that has been provided to me and that the amount may change in the future.

COBRA COVERAGE

I understand I am required by the employer to pay for COBRA benefits

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that any premiums I am obligated to pay for health care coverage for myself and/or any of my dependents will be deducted from my pay on a PRE-TAX basis. This signature also verifies the accuracy of the information on this form.

I have read, understand, and agree to the terms and conditions above.

_____ _____

Employee Signature Required **Date**