Benefit Change Request

EAST SIDE HIGH SCHOOL DISTRICT
Silicon Valley

https://esuhsd.benefithub.com/

A. EMPLOYEE INFORMATION - Per IRS, your name must match the name on your social security card! (Please Print Clearly)

Last Name	First Name	M.I.	Social Security Number	Gender	Date of Birth
			- -	☐ Male ☐ Female	

Street Address	City	State	Zip Code	Marital Status
				☐ Single ☐ Married ☐ Domestic Partner

Are you currently listed as a dependent on any of our medical plans? Yes or No *If yes, name of employee:* _____ | Effective Date / / | Hire Date / / | Phone: Cell or Home ( ) -

Classification: ☐ Certificated ☐ Classified ☐ Administration ☐ Management/Confidential ☐ Adult Ed

B. ABOUT YOUR ENROLLMENT

Choose all that apply:
☐ New Enrollment
☐ HRA Enrollment
☐ Enrollment Change
☐ Name Change
☐ Address Change

Enrollment Change (Must be within 30 days of Status Change)
☐ Add Dependent(s)* ☐ Terminate Coverage
☐ Remove Dependent(s) ☐ Other
* *Proof of dependent eligibility is required.*

☐ Part Time to Full Time OR **Rehire** Date _____

Reason for Status Change* (Indicate date and nature of change):
☐ Marriage ☐ Domestic Partner ☐ Divorce ☐ Coverage Ended
☐ New Born ☐ Adoption or Court Placement
Other _____
* *Proof of status change is required.* Date _____

C. MEDICAL COVERAGE

***Do you have other health coverage through spouse, military or Medicare, etc? ☐ Yes ☐ No If so,name of medical carrier:* _____

☐ **Yes**, I want to enroll in a medical plan and have indicated my choice below for: ☐ **Myself** ☐ **Myself and One Dependent** ☐ **Myself and Family**
☐ **No**, I do not want to enroll myself and my eligible dependents in the medical coverage for this Plan Year.
☐ *I understand that I cannot enroll until the next Open Enrollment unless I experience a "Life Event" and notify the Benefits Office within 30 days of the event.*

Aetna PPO - group # 108423
☐Certificated ☐Classified ☐ Adult Ed
☐ Admin. ☐Mgmt. ☐ Confidential

Aetna HMO - group # 142540
☐ Certificated ☐ Classified ☐ Adult Ed
☐ Admin ☐ Mgmt. ☐ Confidential

Kaiser Permenente HMO
☐Classified - 855 ☐Certificated/Mgmt./Conf. - 24040 ☐Adult Ed - 24200
Kaiser medical record #_____

***Aetna HMO PCP ID#* _____ Visit www.aetna.com

D. DENTAL and VISION COVERAGE

☐ No* ☐ **Yes**, I want to enroll in the **Delta Dental** plan for this Plan Year for: ☐ **Myself** ☐ **Myself and One Dependent** ☐ **Myself and Family**

☐ No* ☐ **Yes**, I want to enroll in the **VSP Vision** plan for this Plan Year for: ☐ **Myself** ☐ **Myself and One Dependent** ☐ **Myself and Family**

**☐ If no, I understand that I cannot enroll until the next open enrollment period; unless I experience a "Qualified Life Event" and I notify my benefits office within 30 days of qualified event.

E. DEPENDENT INFORMATION

Please provide the information requested below for each eligible dependent that you enroll.
Important Note: Please write dependent name(s) as it is listed on the social security card! **Per IRS guidelines, the name must match IRS data

☐ Add ☐ Change ☐ Remove	☐ **Spouse** or ☐ **Domestic Partner** Last Name	First Name	M.I.	Coverage ☐ Medical ☐ Dental ☐ Vision	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
Other Insurance? ☐Yes ☐No **Carrier Name:** _____	**Aetna HMO Enrollees** **PCP ID#** _____			**Kaiser Permanente Enrollees** Former Medical Record # (if known) _____		Totally Disabled ☐ Yes ☐ No	
☐ Add ☐ Change ☐ Remove	**Dependent Child** Last Name	First Name	M.I.	Coverage ☐ Medical ☐ Dental ☐ Vision	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
If children are age 26 or over you must check the appropriate box: IRS Qualified Dependent ☐ Yes ☐ No							
Other Insurance? ☐Yes ☐ No **Carrier Name:** _____	**Aetna HMO Enrollees** **PCP ID#** _____			**Kaiser Permanente Enrollees** Former Medical Record # (if known) _____		Totally Disabled ☐ Yes ☐ No	
☐Add ☐Change ☐Remove	**Dependent Child** Last Name	First Name	M.I.	Coverage ☐ Medical ☐ Dental ☐ Vision	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
If children are age 26 or over you must check the appropriate box: IRS Qualified Dependent ☐ Yes ☐ No							
Other Insurance? ☐Yes ☐ No **Carrier Name:** _____	**Aetna HMO Enrollees** **PCP ID#** _____			**Kaiser Permanente Enrollees** Former Medical Record # (if known) _____		Totally Disabled ☐ Yes ☐ No	
☐ Add ☐ Change ☐ Remove	**Dependent Child** Last Name	First Name	M.I.	Coverage ☐ Medical ☐ Dental ☐ Vision	Date of Birth	Gender ☐ Male ☐ Female	Social Security Number
If children are age 26 or over you must check the appropriate box: IRS Qualified Dependent ☐ Yes ☐ No							
Other Insurance? ☐Yes ☐No **Carrier Name:** _____	**Aetna HMO Enrollees** **PCP ID#** _____			**Kaiser Permanente Enrollees** Former Medical Record # (If known) _____		Totally Disabled ☐ Yes ☐ No	

*** If you are enrolling in the Aetna HMO, please provide your Primary Care Physician (PCP) Code for all new enrollees. Visit www.aetna.com.*

For all enrollments, including changes, please read carefully and if you agree, sign and date all applicable sections.
For example:

Aetna PPO (only H applies) ***Aetna HMO (F and H applies)*** ***Kaiser (G and H applies)***

F. Aetna HMO

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Page 1, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by Aetna Life Insurance Company (referred to as "Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. The plan documents will determine the rights and responsibilities of the employee and dependents and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **California** Employee Enrollment/Change Request form.

Signature (required)	Date (required)

G. KAISER PERMANENTE CALIFORNIA ARBITRATION AGREEMENT

Kaiser Foundation Health Plan, Inc., 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.

Signature Required for all Kaiser Permanente Plans (required)	Date (required)

* Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC Dental plans.

H. RELEASE

I hereby certify that I am an eligible employee/beneficiary as defined in the Summary Plan Document that the above information is complete and accurate, and all claims submitted will be for individuals who are eligible members of the health plan. I hereby authorize the Plan Sponsor to deduct, from my pay, my contributions to the cost of the benefits, which I indicated above and for which I am or may become eligible. The current benefits have been explained to me thoroughly. I understand that I am responsible for a greater portion of my health costs in excess of the amounts payable under the plan.

THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ, UNDERSTOOD, AND AGREE TO ALL SECTIONS AND THE TERMS OF THIS ENROLLMENT FORM.

Signature of Employee (required)	Date

TO BE COMPLETED BY EAST SIDE UNION HIGH SCHOOL BENEFITS DEPARTMENT ONLY

Medical Plan Information:	Input by:	Date:
VSP Plan Information:	Input by:	Date:
Delta Plan Information:	Input by:	Date:
Payroll Information:	Input by:	Date:
Life Insurance Information:	Input by:	Date: