FRESNO UNIFIED SCHOOL DISTRICT

2309 Tulare Street Fresno, CA 93721 (559) 457-3520 Fax No. (559) 457-3760

Open Enrollment Form

COBRA/ED CODE PARTICIPANTS

EFFECTIVE: JANUARY 1, 2016

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID OR SSN NUMBER	☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNERSHIP ☐ LEAVE ☐ COBRA
MAILING ADDRESS		BIRTHDATE / TELEPHONE NO.	☐ MALE ☐ FEMALE
CITY STATE ZIP CODE		Please check your status with Fresno Unified School District ☐ COBRA ☐ ED CODE	

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE _____

Are you or any family members covered by another group plan? ☐ NO ☐ YES _____ GROUP NAME

MEDICAL PLAN OPTION A ☐ CHECK BOX IF NO CHANGE IS REQUIRED

COBRA PREMIUMS

	18 Month Coverage	19 – 29 Month Coverage *
One Party	$ 421.00	$ 620.00
Two Party	$ 843.00	$ 1,240.00
Three Or More	$ 1,231.00	$ 1,811.00

***19 – 29 Month Coverage (extended coverage due to disability)**

Office Visit Co-Pay $15.00

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE PREMIUMS

	MEDICARE	NON-MEDICARE
One Party	$435.00	$ 747.00
Two Party	$870.00	$1,494.00

☐ Employee Only ☐ Add Dependent(s) ☐ Delete Employee ☐ Delete Dependent(s)

MEDICAL PLAN OPTION B ☐ CHECK BOX IF NO CHANGE IS REQUIRED

COBRA PREMIUMS

	18 Month Coverage	19 – 29 Month Coverage*
One Party	$ 376.00	$ 553.00
Two Party	$ 753.00	$ 1,107.00
Three or more	$ 1,100.00	$ 1,618.00

***19 – 29 Month Coverage (extended coverage due to disability)**

Office Visit Co-Pay $25.00

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE PREMIUMS

	MEDICARE	NON-MEDICARE
One Party	$390.00	$ 664.00
Two Party	$781.00	$1,331.00

☐ Employee Only ☐ Add Dependent(s) ☐ Delete Employee ☐ Delete Dependent(s)

MEDICAL PLAN OPTION C ☐ CHECK BOX IF NO CHANGE IS REQUIRED

KAISER PERMANENTE HEALTH PLAN and SENIOR ADVANTAGE

COBRA PREMIUMS

	18 Month Coverage	19 – 29 Month Coverage*
One Party	$ 992.00	$ 1,488.00
Two Party	$ 992.00	$ 1,488.00
Three or more	$ 992.00	$ 1,488.00

*19 – 29 Month Coverage (extended coverage due to disability)

Office Visit Co-Pay $15.00

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE PREMIUMS

	MEDICARE(Senior Advantage)	NON-MEDICARE
One Party	$ 284.09	$ 743.76
Two Party	$ 568.18	$ 1,487.52
Two Party (Spouse under 65)	$ 741.15	N/A

☐ Employee Only ☐ Add Dependent(s) ☐ Delete Employee ☐ Delete Dependent(s)

DENTAL PLANS ☐ CHECK BOX IF NO CHANGE IS REQUIRED

DELTA DENTAL PPO

COBRA PARTICIPANTS

Family coverage is available at the rates listed.

Cross Coverage is not available

	Monthly Cost: 12 Month
Employee	$ 42.00
One Dependent	$ 85.00
Two or more	$126.00

Maximums	PPO	NON-PPO
Per patient per calendar year	$2,000	$1,000
Dental Accident per calendar year	$1,000	$1,000
Orthodontic lifetime maximum	N/A	N/A

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE PARTICIPANTS

Monthly Premiums

RETIREE	$ 42.00
RETIREE/SPOUSE	$ 85.00

Employee and Family
MUST USE PPO PROVIDER FOR PPO COVERAGE

☐ Employee Only ☐ Add Dependent(s)
☐ Delete Employee ☐ Delete Dependent(s)

UHC/PACIFIC UNION

COBRA PARTICIPANTS

Employee and Family $ 51.00

Includes Orthodontic coverage for dependents between ages 10 and 19. Some procedures may require co-payments.

Plan coverage includes:
Office Exam, X-Rays, and (2) Cleanings Annually

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family
☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE RETIREES

Monthly Premiums

RETIREE	$29.00
RETIREE/SPOUSE	$58.00

Employee and Family
MUST USE UHC/PACIFIC UNION Provider

☐ Employee Only ☐ Add Dependent(s)
☐ Delete Employee ☐ Delete Dependent(s)

VISION PLAN

☐ CHECK BOX IF NO CHANGE IS REQUIRED

MEDICAL EYE SERVICES (MES)

COBRA PARTICPANTS

Office Visit Co-Pay $5.00

Employee Only..... $ 12.00

NO ADDITIONAL COST TO EMPLOYEE FOR FAMILY COVERAGE

Plan coverage:
Exam: Once every 12 months
Lenses: Once every 12 months (If Rx changes)
Frames: Once every 24 months

☐ Employee Only ☐ Add Dependent(s) ☐ Add Family ☐ Delete Employee ☐ Delete Dependent(s) ☐ Delete Family

ED CODE PARTICIPANT

Monthly Premiums

RETIREE $ 7.00
RETIREE/SPOUSE $ 11.00

☐ Employee Only ☐ Add Dependent(s) ☐ Delete Employee ☐ Delete Dependent(s)

FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:
BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES / SS# COPY

FIRST NAME	LAST NAME	GENDER	AGE	BIRTHDATE	SOCIAL SECURITY
☐ DOMESTIC PARTNER ☐ SPOUSE		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			
☐ SON ☐ DAUGHTER		F / M			

- **The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.**

- **Please notify the Benefits Office of any change in Health Coverage within 31 days of event.**

Verified by:	Effective Date:

EMPLOYEE SIGNATURE_____ **Date** _____

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

Company name FRESNO UNIFIED SCHOOL DISTRICT		Hire date (mm/dd/yyyy)
Group number 603815	Enrollment unit 0000	Effective enrollment/ change date

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: ☒ Yes ☐ No

☐ New Hire (complete sections A, B, C, D) ☒ Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) ☐ HMO Plan ☒ Deductible Plan ☐ Other

B. EMPLOYEE: Have you ever been a Kaiser Permanente member? ☐ Yes ☐ No

Medical Record No. (if known) Social Security No.

Name (Last, First, MI) Birth Date (mm/dd/yyyy) Gender ☐ M ☐ F

Home Address City State ZIP

Work Phone Home Phone Email

Ethnicity Preferred Language

C. FAMILY: For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

☐ Add ☐ Delete ☐ Spouse ☐ Domestic partner Spouse/domestic partner name: Former last name (if any):	Gender ☐ M ☐ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Child Dependent name: Relationship:	Gender ☐ M ☐ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Child Dependent name: Relationship:	Gender ☐ M ☐ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
☐ Add ☐ Delete ☐ Child Dependent name: Relationship:	Gender ☐ M ☐ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

Do any of dependents above live at another address? : ☐ Yes ☐ No If yes, complete the following:

Name (Last, First, MI): Address:

D. <u>Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*</u>

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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 and in the Certificate of Insurance.

*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.

☒ _____

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) Date

KAISER PERMANENTE®

Note: Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.