FRESNO UNIFIED SCHOOL DISTRICT

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

Open Enrollment Form
Medicare Eligible Retirees
Effective January 1, 2017

RETIREE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID OR SSN NUMBER	☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNERSHIP
MAILING ADDRESS			
CITY / STATE / ZIP CODE	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE

OTHER HEALTH INSURANCE INFORMATION

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

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

DENTAL PLANS

☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

DELTA DENTAL PPO (DISTRICT PLAN)

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate
Retiree Only	$ 44.00	$ 44.00
Retiree and Spouse	$ 89.00	$ 89.00
Retiree and Family	$132.00	N/A

***Dependent child(ren) coverage is no longer provided to retirees on ED Code 7000 effective September 1, 2013**

MUST USE PPO PROVIDER FOR PPO COVERAGE

- ☐ ADD Coverage
- ☐ Retiree Only
- ☐ Add Spouse/DP
- ☐ Add Dependent(s)
- ☐ DROP Coverage
- ☐ Delete Spouse
- ☐ Delete Dependent(s)

UHC DENTAL DIRECT

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate
Retiree Only	$ 51.00	$ 29.00
Retiree and Spouse	$ 51.00	$ 58.00
Retiree and Family	$ 51.00	N/A

***Dependent child(ren) coverage is no longer provided to retirees on ED Code 7000 effective September 1, 2013**

MUST USE UHC DENTAL DIRECT PROVIDERS

- ☐ ADD Coverage
- ☐ Retiree Only
- ☐ Add Spouse/DP
- ☐ Add Dependent(s)
- ☐ DROP Coverage
- ☐ Delete Spouse
- ☐ Delete Dependent(s)

VISION PLAN

☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

MEDICAL EYE SERVICES (MES)

RETIREES AGE 65 AND UP

Monthly Premiums

	COBRA Rate	Ed Code Rate
Retiree Only	$ 12.00	$ 7.00
Retiree and Spouse	$ 12.00	$ 11.00
Retiree and Family	$ 12.00	N/A

Plan coverage:
Exam – Once every 12 months …. $5. Co-Pay
Lenses – Once every 12 months …. (If Rx change)
Frames – Once every 24 months …. $0 (Frames or Lenses)

- ☐ ADD Coverage
- ☐ Retiree Only
- ☐ Add Spouse/DP
- ☐ Add Dependent(s)
- ☐ DROP Coverage
- ☐ Delete Spouse
- ☐ Delete Dependent(s)

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

Premiums	65-74	75+
Retiree Only	**$10.00**	**N/A**
Retiree & Child	**$20.00**	**N/A**
Retiree & Spouse /Domestic Partner	**$20.00**	**N/A**
Retiree & Family	**$40.00 Max***	**N/A**

Office Visit Co-Pay $15.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

	PPO Providers	Non PPO
Covered Services	80% of Blue Cross rate	60% of UCR*
Calendar Year Deductible	$250 Individual	$750 Individual
	$500 Family	$1,500 Family
Annual Out-Of Pocket Maximum	$4,700 Individual	$10,000 Individual
	$9,400 Family	$20,000 Family

***Usual, Customary and Reasonable**

- ☐ **ADD Coverage**
- ☐ **Retiree Only**
- ☐ **Add Spouse/DP**
- ☐ **Add Dependent(s)**
- ☐ **Drop Coverage**
- ☐ **Delete Spouse**
- ☐ **Delete Dependent**

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

Premiums	65-74	75+
Retiree Only	**$10.00**	**N/A**
Retiree & Child	**$20.00**	**N/A**
Retiree & Spouse Domestic Partner	**$20.00**	**N/A**
Retiree & Family	**$40.00 Max***	**N/A**

Office Visit Co-Pay $25.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

	PPO Providers	Non PPO
Covered Services	70% of Blue Cross rate	50% of UCR*
Calendar Year Deductible	$1,000 Individual	$3,000 Individual
	$2,000 Family	$6,000 Family
Annual Out-Of Pocket Maximum	$5,700 Individual	$12,000 Individual
	$11,400 Family	$24,000 Family

***Usual, Customary and Reasonable**

- ☐ **ADD Coverage**
- ☐ **Retiree Only**
- ☐ **Add Spouse/DP**
- ☐ **Add Dependent(s)**
- ☐ **Drop Coverage**
- ☐ **Delete Spouse**
- ☐ **Delete Dependent**

MEDICAL PLAN OPTION C

☐ **CHECK BOX IF NO CHANGE IS REQUIRED**

ALTERNATE MEDICAL PLAN ADVANTAGE

Premiums	65-74	75+
Retiree Only	$10.00	N/A
Retiree & Child	$20.00	N/A
Retiree & Spouse /Domestic Partner	$20.00	N/A
Retiree & Family	$40.00 Max*	N/A

KAISER PERMANENTE SENIOR

If you are choosing Kaiser Permanente Senior Advantage for your coverage, you must also complete the KAISER ENROLLMENT FORM (California Region Group Enrollment/Change Form) and the KAISER SENIOR ADVANTAGE FORM (Group Election Request Form).

Office Visit Co-Pay $15.00

Note: No cost for Retiree or Spouse when age 75+ is reached.

Covered services for care must be obtained at a Kaiser facility (Except in emergencies)

Covered Services	Most 100% after Applicable Co-Pay		
Calendar Year Deductible	None		
Annual Out-Of Pocket Maximum	$1,500 Individual	$3,000 Family	Max

Kaiser Permanente enrolled participants will continue to use the Plan's Chiropractic benefits provided through ChiroMetrics and the Plan's Employee Assistance Program (EAP) benefits through Claremont EAP. The Kaiser Permanente Senior Advantage Plan includes Mental Health, Substance Abuse and Vision benefits as noted on the comparison.

☐ **ADD Coverage**	☐ **Drop Coverage**
☐ **Retiree Only**	☐ **Delete Spouse**
☐ **Add Spouse/DP**	☐ **Delete Dependent**
☐ **Add 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			

Verified by:	Effective Date:

RETIREE 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 0002	Effective enrollment/ Change Date **01/01/2017**

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. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

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.