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

SPECIAL BENEFITS ENROLLMENT

EFFECTIVE: JUNE 1, 2018

COBRA PARTICIPANTS

1. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	FUSD EMPLOYEE I.D.	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ DOMESTIC PARTNERSHIP

MAILING ADDRESS	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	DEPARTMENT / SCHOOL

2. OTHER HEALTH INSURANCE INFORMATION

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

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

3. HEALTH PLAN OPTIONS: (If you do not wish to change your Medical Plan, NO ACTION is required.)

MEDICAL PLAN OPTION A

☐ ENROLL UNDER PLAN A ☐ DISENROLL FROM PLAN A

Premiums:

	18 Mo. Coverage	19 – 29 Mo. Coverage
One Party	**$ 465**	**$ 683**
Two Party	**$ 930**	**$ 1,368**
Three or More	**$ 1,357**	**$ 1,996**

Office Visit Copay $ 15.00

	PPO Providers	NON PPO Providers
Covered Services:	90% of Blue Cross Rate	60% of UCR*
Calendar Year Deductible:	$ 250 Individual $ 500 Family	$ 750 Individual $ 1,500 Family
Annual Out-of-Pocket Maximum:	$ 2,100 Individual $ 4,200 Family	$ 10,000 Individual $ 20,000 Family

*Usual Customary and Reasonable

MEDICAL PLAN OPTION B

☐ ENROLL UNDER PLAN B ☐ DISENROLL FROM PLAN B

Premiums:

	18 Mo. Coverage	19 – 29 Mo. Coverage
One Party	**$ 415**	**$ 610**
Two Party	**$ 831**	**$ 1,221**
Three or More	**$ 1,213**	**$ 1,784**

Office Visit Copay $ 25.00

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

*Usual Customary and Reasonable

MEDICAL PLAN OPTION C

☐ ENROLL UNDER PLAN C ☐ DISENROLL FROM PLAN C

If you are choosing Kaiser Permanente Health Plan for your coverage, you must also complete the KAISER ENROLLMENT FORM (California Region Group Enrollment/Change Form) on the back of this form.

Premiums:

	18 Mo. Coverage	19 – 29 Mo. Coverage
One Party	**$ 1,021**	**$ 1,531**
Two Party	**$ 1,021**	**$ 1,531**
Three or More	**$ 1,021**	**$ 1,531**

Office Visit Copay $ 15.00

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

Covered Services:	90% after Deductible
Calendar Year Deductible:	$ 250 Individual $ 500 Family
Annual Out-of-Pocket Maximum:	$ 2,500 Individual $ 5,000 Family

If you enroll under Kaiser, you will have Vision coverage through Kaiser.

* 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.

EMPLOYEE SIGNATURE_____ **DATE** _____

Verified by:	Effective 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: 7000 (COBRA)	Effective enrollment/ change date: **06/01/2018**

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: Special Enrollment (complete sections A, B, C, D)

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.

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., 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 **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

KAISER PERMANENTE®