Universal Enrollment Form
Medical Insurance for Part time (Adjunct) Participants

Effective Date: _______January 1_ , 20 24___

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: ( ) -	Hours Worked Weekly:
Email Address:			

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: ________________
☐ COBRA Continuation - Effective Date: ________________
☐ 18 month ☐ 29 months ☐ 36 months

☐ Name Change* - Event Date: ________________
(*Please fill in New and Previous Name below)
New Name: __________________________________
Previous Name: __________________________________
☐ Deleting Dependent(s) - Event Date: ______________________
☐ Terminating Coverage - Event Date: ____________________
☐ Other: ______________________ Event Date: ________________

SECTION 3. Medical Coverage Election

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

☐ **Kaiser Permanente HMO** **$5 co-pay Group #: 421-0002**	☐ **Kaiser Permanente HMO** **$20 co-pay Group #: 421-0004**

MEDICAL

☐ Employee Only
☐ Employee + One
☐ Employee + Family Coverage

SECTION 4. Participant(s) Information (For more participants, use a separate piece of paper)

(A)dd **(Con)**tinue **(C)**hange **(D)**elete	Relationship	Name (Last, First, M.I.)	Social Security Number	Date of Birth & Age	Gender	Totally Disabled
	Self		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No
	☐Spouse ☐Domestic Partner		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No
	Child 1		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No

	Child 2		- -	/ / Age:	☐ M ☐ F	☐ Yes ☐ No

Have you included stepchildren as dependents? ☐ NO ☐ YES - If "yes" indicate name/s: ______________________________
Do your stepchildren reside with you? ☐ NO ☐ YES Are they dependents upon you for support and maintenance? ☐ NO ☐ YES
(Note: If you have more than three children, please attach a 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			
Child 4			

For Current/Previous 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:______________________________

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

Name(s) of Medicare Dependent(s)
____
____

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)
☐ Self
☐ Spouse / Domestic Partner
☐ Child(ren)

REASON
☐ Have Other Group Coverage. Name of Insurance: ______________________________
☐ Have Other Individual Coverage. Name of Insurance:______________________________
☐ Other (Explain): ______________________________
____

Insurance Plan(s) you are choosing to waive (Check all that apply): ☐ **Medical**

I hereby elect to decline enrollment for coverage under the CLPCCD insurance plan(s) checked above for the coming 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:____________

Kaiser Foundation Health Plan Arbitration Agreement – For All Kaiser Participant

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.

____ _______________________________

Employee 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.

All monthly premium payments for medical benefits will be deducted directly from the unit member's monthly paycheck. Unit member authorizes the District to deduct money owed from their paycheck. If the premiums due are not received by the 10th of the month following notification that past due premiums are owed, the District shall cancel the member's medical benefits and proceed to collect past due premiums. Unit members will be billed for the collection of past due premiums and if not fully paid within thirty days from the date of notification, premium will be debited from future earnings or via other collection remedies.

COVERAGE

I understand I am required by the employer to pay for elected 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**