

	<input type="checkbox"/> New Enrollment (complete all) <input type="checkbox"/> Change (complete reason) <input type="checkbox"/> Termination (name, SS# & termination date)	Reason for Change Name (fill in now Name in Put One) _____ Address (fill in new address in Part One) _____	Add/Delete Spouse/Partner/Dependents Add new baby _____ Delete spouse/partner _____ Delete child(ren) _____ Date: _____ Add new spouse/partner _____ Date of Marriage _____ Add new child(ren) (Court order or marriage) _____	School District/Community College _____ Date of Hire: ____/____/____ Are you transferring from another district? Yes ___ No ___ Name of School: _____
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Employee's Name: Last _____ First _____ MI _____ Social Security Number: _____ Date of birth: _____

P A R T O N E	Address: _____ City _____ State _____ Zip _____ Home Phone Number: () _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Reg. Domestic Partnership <input type="checkbox"/> Divorced
	Employee Job Title: <input type="checkbox"/> Admin.Mgmt <input type="checkbox"/> Board <input type="checkbox"/> Confidential		<input type="checkbox"/> Certified <input type="checkbox"/> Classified <input type="checkbox"/> Part Time

Are you or your dependents currently covered under any other Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Children Is your Spouse/Partner a full-time employee with benefits offered? Yes ___ No ___ Does the employer offer a plan that costs \$100 or less? Yes ___ No ___ If you responded yes to the two above questions, your spouse/partner needs to enroll in the minimum employer insurance. This can be employee only and not family coverage. Employer _____ Phone# _____ Carrier(s): Policy/ID #(s): _____ Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicare # _____	Coverages: (For Part-time, Pro-rated Employees, Board Members - a No is a Declination of Coverage) Medical: Option 1-Gold _____ Option 1-Silver _____ NO: _____ Red Plan _____ Blue Plan _____ Option II _____ Dental: Yes: _____ No: _____ Vision: Yes: _____ No: _____
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Add/Delete Eligible Dependent(s): Legal Spouse, Registered Domestic Partner and/or IRS Dependent Children (Attach Marriage, DP & Birth Certificates)

Circle Relationship	Last Name	Eligible Dependents			Date of Birth	Verified Certificates	Social Security No.	Check or Circle Choices:
		First	MI					
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Partner								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Authorization - Please read carefully. Authorization to obtain or release medical information - Butte Schools Self-Funded Programs (BSSP) is authorized to obtain and release medical information in compliance with HIPAA and any other insurance and privacy protection act.

- I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish an agent, designee or representative of Blue Cross of California, Delta dental, Vision Service or Butte Schools Self-Funded Programs any and all records to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation or evaluation of an application or a claim.
- I also authorize BSSP or its agents, designees or representative to disclose to a hospital, self-insurer or insurer any such medical information obtained if such disclosure is necessary to allow the processing of the claim.
- The authorization shall become effective immediately and shall remain in effect as long as necessary to enable BSSP to process claims and establish rates.
- I understand I am responsible for a greater portion of my medical costs when I use a non-participating provider.
- I understand any dispute between myself (and/or enrolled family member) and Blue Cross of California, Delta Dental or Vision Service Plan, or any affiliate, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the small Claims Court and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage the member and Blue Cross of California, Delta Dental or Vision Service Plan are giving up the right to have any dispute decided in a court of law before a jury.
- My spouse/partner's employer may be contacted to verify coverage.

I DECLARE, UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT. REPAYMENT NECESSARY ON ANY CLAIMS PAID FRAUDULENTLY.

Signature: _____ Date: _____

EMPLOYER'S SECTION										HIPAA/COBRA Information:										
Date of Eligibility/Termination			Medical Code			Dental Code:			Vision Code:			Other Code:			Qualifying Event: <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Loss of Coverage (HIPAA)					
Life Code:															<input type="checkbox"/> Death of Employee <input type="checkbox"/> Divorce or Separation <input type="checkbox"/> Loss dep. child eligibility <input type="checkbox"/> Other _____					
Amount: \$			Mo Day Yr			Mo Day Yr			Mo Day Yr			Mo Day Yr			Date of Event: ____/____/____ Date of loss of coverage: ____/____/____					