REQUIRED INFORMATION	
District Use Only	
District Name:	
❑ SISC bills District	❑ SISC bills Retiree
Medical Group No.	Effective Date
Dental Group No.	Vision Group No.
Bargaining Unit:	

SISC Enrollment Form for following plans:

- ❑ **PPO Retiree 65+ with Medicare A&B (EGWP Rx)**
- ❑ **CompanionCare – Medicare A&B Supplement (Part D Rx)**

Please choose one:

❑ I am the Retiree

❑ I am the Spouse or Domestic Partner (provide name and SSN of the retiree). Separate enrollment form required.

Retiree name	Retiree SSN

Applicant Name: ____
(as it appears on Medicare card) (Last) (First) (Middle Initial)

Social Security Number: ____________________ Date of Birth: ______________
(MM / DD / YYYY)

❑ Male ❑ Female

Email address: __________________________ Phone Number: ______________

Home Address:

____
Street, Apt. No., Suite No. City State Zip

I am currently covered under Medicare for:
❑ Hospital Part A (Date):____________ ❑ Medical Part B (Date):____________

I am not currently covered under Medicare Parts A&B. It will be effective on the following dates:
❑ Hospital Part A (Date):____________ ❑ Medical Part B (Date):____________

Medicare Beneficiary Identifier (MBI) Required: ______________________________
(Please attach a photocopy of your Medicare card)

SISC Enrollment Form for following plans:

- **PPO Retiree 65+ with Medicare A&B (EGWP Rx)**
- **CompanionCare – Medicare A&B Supplement (Part D Rx)**

Applicant Name: ____

(Last) (First) (Middle Initial)

I understand that the following conditions apply as a part of this coverage:

1. Continuous enrollment in Medicare A&B is required.
2. I understand SISC will automatically enroll member(s) in Medicare Part D.
3. I understand if my doctor does not accept Medicare Assignment, I will be responsible for the difference between the Medicare allowable charge and the doctor's billed charges.
4. This application form, a copy of the applicant's Medicare card and Declaration of Prior Prescription Drug Coverage **MUST** be received by SISC **45 calendar days** in advance of the requested effective date.
5. To CANCEL this coverage, the SISC Disenrollment form MUST be completed and received by SISC 45 calendar days in advance of the requested termination date. Both Medical and Prescription drug benefits will be canceled.
6. I understand it will be my responsibility as the applicant to notify Medicare at 1-800-Medicare (1-800-633-4227) within 63 days after coverage ends to select a new Medicare Part D plan.
7. I understand I can only be in one Medicare prescription drug plan at a time – if I am currently enrolled in a Medicare Prescription Drug Plan other than Navitus MedicareRx, my enrollment in Navitus MedicareRx (PDP) will terminate that enrollment.

Please Read and Sign Below

ARBITRATION AGREEMENT:

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND SISC III (INCLUDING CLAIMS ADMINISTRATOR OR AFFILIATE) INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, 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, BOTH THE MEMBER AND SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. SISC III AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. (FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE BOOKLET.)

Applicant Signature Required: ________________________________ Date: ______________

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: ________________________

Member Name: ____

Address: ____

____

Phone: ____

Member ID: <Member ID>

Medicare Health Insurance Claim # or your MBI: ________________________

(From red, white and blue Medicare card)

Name of Medicare Prescription Drug Plan: ___________________________________

Please check all boxes that apply to you.	**Dates of Coverage (month/year)**
I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP). Name: __________________________________	From: __________________ To: __________________
I never had creditable* drug coverage	

* "Creditable" means that your prior coverage met Medicare's minimum standards.

Please complete the signature section on the following pages.

☐	I had prescription drug coverage through my TRICARE or other military coverage.	From: ____________________ To: ____________________
☐	I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage.	From: ____________________ To: ____________________
☐	I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: ____________________ To: ____________________
☐	I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: ____________________ To: ____________________
☐	I had creditable* prescription drug coverage from a different source not listed above. Name of other source: ______________________	From: ____________________ To: ____________________
☐	I have/had extra help from Medicare to pay for my prescription drug coverage.	From: ____________________ To: ____________________
☐	I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: ____________________________	From: ____________________ To: ____________________
☐	I never had creditable* drug coverage	

* “Creditable” means that your prior coverage met Medicare’s minimum standards.

Please complete this section:

“To the best of my knowledge, the information on this form is true and correct. I understand that if I didn’t have creditable coverage and/or don’t give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Navitus MedicareRx (PDP) by Medicare.”

Signature: ____

Date: *(month/day/year):* _____________________________________

If you are the representative, you must provide the following information:

Name: ____

Address: ____

____

City: ___________________________ State: _______ ZIP: _________

Phone Number: (______) _________- ______________

Relationship to Member: _____________________________________