



REQUIRED INFORMATION District Use Only	
District Name:	
<input type="checkbox"/> SISC bills District	<input type="checkbox"/> 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: _____



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: _____
<input type="checkbox"/> 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: _____

The Centers for Medicare & Medicaid Services (CMS) requires the following race and ethnicity questions to be included on the enrollment form; however, applicant response to these questions is optional.

Ethnicity	Preferred Language Other than English
<input type="checkbox"/> Not of Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Another Hispanic, Latino or Spanish Origin <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Cuban <input type="checkbox"/> I choose not to answer	<input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> No Selected Preference
	Accessible Format <input type="checkbox"/> Braille <input type="checkbox"/> Large Print <input type="checkbox"/> Audio CD
Race	
<input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> I choose not to answer