SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

District Use Only	
District Name:	
Medical Group No.	Effective Date
Dental Group No.	Vision Group No.

SISC PPO 65+ Retiree Medical Coverage Form for Medical and Prescription Drug Benefits (Continuous enrollment in Medicare A&B required)

SISC will automatically enroll member(s) in Medicare Part D

Applicant Name: Smith (Last) John (First) D. (MI)

must list all numbers

Social Security Number: XXX-XX-XXXX Date of Birth: MM/DD/YYYY (MM / DD/ YYYY)

☒ Male ☐ Female Email address: JohnDoeSmith@fakeemail.com

Home Address:

123 First Street, Modesto, CA 95352
Street, Apt. No., Suite No. City State Zip

Care of/Attention: (only if you have someone who handles things for you) Home Phone Number: 209-555-1212

Billing Address:

PO Box 123 Modesto CA 95352
(If different from home address)

If transferring from another group or plan, indicate:

I am covered under Medicare for: ☐ Hospital Part A ☐ Medical Part B ☐ Part D Prescription Drugs

I am not currently covered under Medicare Parts A & B ☒ I will be covered effective Date on card

Medicare ID Number Required: write number & attach a copy of card
(Please attach a photocopy of your Medicare card)

SISC PPO 65+ Retiree Medical Coverage Form
For Medical and Prescription Drug Benefits
(Continuous enrollment in Medicare A&B required)

Applicant Name: Smith (Last) John (First) D (MI)

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

1. Health conditions which you may presently have (pre-existing conditions) will be covered immediately.
2. If your doctor does not accept Medicare Assignment, you will be responsible for the difference between the Medicare allowable charge and the doctor's billed charges.
3. This application form and a copy of the applicant's Medicare card **MUST** be received by SISC **45 calendar days** in advance of the requested effective date. **No Exceptions.**
4. If you lose coverage of Medicare Part A, B or both at any time, you will lose coverage of both Medical and Prescription drugs effective the date you lost the Medicare coverage.
5. To CANCEL this coverage, the request **MUST** be received by SISC **45 calendar days** in advance of the requested termination date. Both Medical and Prescription drug benefits will be canceled at the same time.
6. It will also be your 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. You can only be in one Medicare prescription drug plan at a time – if you are currently in a Medicare Prescription Drug Plan other than Navitus MedicareRx, your enrollment in Navitus MedicareRx (PDP) will end 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: John Doe Smith **Date:** date 2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: MM-DD-YYYY

Member Name: John D. Smith

Address: 123 First St.
Modesto CA 95352

Phone: 209-555-1212

Member ID: <Member ID> # off your card

Medicare Health Insurance Claim # or your MBI: (not needed)

(From red, white and blue Medicare card)

Name of Medicare Prescription Drug Plan: (leave blank)

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: SISC III / Blue Shield / Navitus	From: date of benefits To: date on Medicare card
☐ 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 page.

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: John Doe Smith

Date: *(month/day/year)*: MM/DD/XXXX

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

Name: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Phone Number: (____) _____ - _____

Relationship to Member: _____

only if an executor or power of attorney is completing

Keep these for your records

NOTICE OF PRIVACY PRACTICES
FOR THE USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 3, 2006
Anyone has the right to ask for a paper copy of this Notice at any time.

Q. Why are you providing this Notice to me?
A. The SISC Health Benefits Plan is required by federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your Protected Health Information (PHI) is kept private. This law applies to the health benefits offered through SISC, including SISC Flex, the Health Reimbursement Arrangements (SISC HRA) and the Health Savings Account (SISC HSA). We must give you this Notice of our legal duties and Privacy Practices with respect to your PHI. We are also required to follow the terms of the Notice that is currently in effect. PHI includes information that we have created or received about your past, present, or future health or medical condition that could be used to identify you. It also includes information about medical treatment you have received and about payment for health care you have received. We are required to tell you how, when, and why we use and/or share your Protected Health Information (PHI).

Q. How and when can you use or disclose my PHI?
A. HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI. We describe in this Notice the reasons we may use your PHI without getting your permission. Not every use or disclosure is listed, but the ways we can use and disclose information fall within one of the descriptions below.

So you can receive treatment. We may use and disclose your PHI to those who provide you with health care services or who are involved in your care. These people may be doctors, nurses, and other health care professionals. For example, if you are being treated for a knee injury, we may give your PHI to the people providing your physical therapy. We may also use your PHI so that health care can be offered or provided to you by a home health agency.

To get payment for your treatment. We may use and disclose your PHI in order to bill and get paid for treatment and services you receive. For example, we may give parts of your PHI to our billing or claims department or others who do these things for us. They can use it to make sure your health care providers are paid correctly for the health care services you received under a health plan.

To operate our business. We may use and disclose your PHI in order to administer our health plans. For example, we may use your PHI in order to review and improve the quality of health care services you receive. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are obeying the laws that affect us. Another time when we may provide PHI to other organizations is when we ask them to tell us about the quality of our health plans and how we operate our business. Before we share PHI with other organizations, they must agree to keep your PHI private.

To meet legal requirements. We share PHI with government or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we are required to in a court or other legal proceeding. For example, if a law says we must report private information about people who have been abused, neglected, or are victims of domestic violence, we share PHI.