NEW RETIREE ENROLLMENT FORM - Yosemite Community College District

(Type or print clearly in blue or black ink)

Plan Term 2022-23

SECTION I. SELECTED COVERAGE - REQUIRED (DISTRICT USE ONLY)

YCCD USE ONLY

Retirement Date:		Retiree Benefits Effective:		Bargaining Unit:	
MEDICAL PLAN #	MEDICAL PREM $	DELTA DENTAL GROUP #	DELTA DENTAL PREMIUM $	VSP GROUP #	VSP PREMIUM $

SECTION II: EMPLOYEE/APPLICANT INFORMATION - REQUIRED **CHOOSE PLAN(S) BELOW - AND COMPLETE ENROLLMENT INFORMATION**

Spouse & eligible dependents will be enrolled on your Medical plan unless you exclude them (contact Benefits for the form).

RETIREE INFORMATION

☐ Dental ☐ Vision ☐ *Decline Dental* ☐ *Decline Vision* ☐ Male ☐ Female

LAST NAME (PRINT)	FIRST NAME	MI	AGE	DATE OF BIRTH
				/ /

SOCIAL SECURITY NUMBER	CLASSIFICATION (Classified/Management/Faculty)	Medicare A Eff:	Medicare B Eff:

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NUMBER	E-MAIL ADDRESS
( )	

SPOUSE / Reg.Domes.Partn.

☐ Dental ☐ Vision ☐ *Decline Dental* ☐ *Decline Vision* ☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female

LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	AGE	DATE OF BIRTH
				/ /

SOCIAL SECURITY NUMBER	E-MAIL ADDRESS	Medicare A Eff:	Medicare B Eff:

ELEGIBLE DEPENDENT(S)

☐ Dental ☐ Vision ☐ *Decline Dental* ☐ *Decline Vision* ☐ Son ☐ Daughter ☐ Totally Disabled (Y/N?)

LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	AGE	DATE OF BIRTH
				/ /

SOCIAL SECURITY NUMBER	E-MAIL ADDRESS	Medicare A Eff:	Medicare B Eff:

☐ Dental ☐ Vision ☐ *Decline Dental* ☐ *Decline Vision* ☐ Son ☐ Daughter ☐ Totally Disabled (Y/N?)

LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	AGE	DATE OF BIRTH
				/ /

SOCIAL SECURITY NUMBER	E-MAIL ADDRESS	Medicare A Eff:	Medicare B Eff:

MEDICAL PLAN CHOICES - PLEASE READ THIS SECTION CAREFULLY

IMPORTANT INFORMATION FOR PERSONS WITH MEDICARE A & B COVERAGE:

If all parties to be covered by YCCD's Medical Plans have Medicare A/B, you must enroll in one of the "OVER" plans below.
These Blue Shield plans will be enrolled into a Medicare D Prescription Coverage through Navitus Prescription Solutions.
Per Federal regulations - you may *not carry more than one* Medicare D plan.
If any participant is *under 65* and/or does not have Medicare A/B - ALL parties must remain on an "UNDER" plan.
Please refer to the 2022-23 Monthly Premium Rate Sheet for costs.

"UNDER" PLANS (Select if even 1 person is under 65/does not have Medicare A&B)

- ☐ Kaiser HMO - Anyone over 65w/A&B must enroll individually in KPSA
- ☐ Blue Shield 80-G
- ☐ Blue Shield 80-C
- ☐ Blue Shield 90-G
- ☐ Blue Shield 100-D

"OVER" PLANS (Select only if all parties have Medicare A&B)

- ☐ Kaiser Permanente Senior Advantage (KPSA)
- ☐ Blue Shield 100-A ($0-35 Rx) (inc. Medicare D pres coverage)
- ☐ Blue Shield 100-A ($200/0-35 Rx) (inc. Medicare D pres coverage)
- ☐ CompanionCare (inc. Medicare D pres coverage)

Select level of medical coverage -> Single: ☐ 2-party: ☐ Family: ☐

Please note - New enrollment forms are required if changing from Kaiser to Blue Shield or from Blue Shield to Kaiser.

Select Dental and Vision coverage below. Also select number to be covered under each plan.

☐ **DELTA DENTAL GROUP #1** Premier/Incentive Plan
- ☐ 1 Person: $62.20/mo
- ☐ 2 Person: $125.00/mo
- ☐ Family: $174.40/mo

☐ **DELTA DENTAL GROUP #2** ** SEE NOTE! PPO / 100% Plan
- ☐ 1 Person: $57.00/mo
- ☐ 2 Person: $114.00/mo
- ☐ Family: $150.00/mo

VSP VISION PLAN
- ☐ 1 Person: $12.40/mo
- ☐ 2 Person: $24.80/mo
- ☐ Family: $37.20/mo

**** NOTE: The PPO plan has a fewer number of service providers. Benefits may be reduced by 50% if your Dentist is not a preferred PPO dentist. Check with www.deltadentalins.com to make sure your dentist is contracted with the PPO plan.**

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SISC III - RETIREE ENROLLMENT FORM - YCCD P 2 of 2

Initial each item and sign below to show you have read and understand:	
	I understand that I can opt into Dental and/or Vision only at my retirement and cannot do so later. Also, if I cancel Dental and/or Vision at any time, I cannot opt in again.
	I acknowledge that it is my responsibility to notify my District once a dependent is no longer eligible due to divorce or aging out (children). If I fail to report loss of eligibility, I may be financially liable to SISC if claims were paid on behalf of non-eligible individuals.
	NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
	HIV TESTING PROHIBITED: CA law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
	EFFECTIVE DATE: The effective date of all coverage is subject to SISC III approval.
	COMPLAINTS: Any complaints regarding the exemption due to the Knox-Keene Health Care Service Plan Act of 1975 may be directed to the Department of Managed Health Care of the State of California.

Signature Required _____ Date _____

SECTION IV: SIGNATURE OF UNDERSTANDING - APPLICANT MUST SIGN

I have read and understood the provisions outlined on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. (You are entitled to a copy of this signed authorization for your files.) Additionally, any person who knowingly and with intent to injure, defraud, or deceive YCCD, SISC, or plan service provider, by filing a statement or claim containing false or misleading information, may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

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.)

Signature Required _____ Date _____