SISC III ENROLLMENT FORM - Yosemite Community College District **RETIREE: Choose Dental and/or Vision**

(Type or print clearly in black ink) **2017-18 Revised Rates**

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

Enrollment Reason: ⊗ Employee Status Change (Retirement)			
Qualifying Date:	Effective Date:	District Approval:	
DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT -Certificated/Classified/Management)		FTE
DELTA DENTAL GROUP NUMBER	DELTA DENTAL PREMIUM	VISION PLAN GROUP NUMBER	VISION PLAN PREMIUM

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

☐ DELTA DENTAL GROUP #1 Premier/Incentive Plan	☐ 1 Person - $ 64.00/month ☐ 2 Person - $128.00/month ☐ Family - $168.00/month	VSP VISION PLAN	☐ 1 Person - $12.40/month ☐ 2 Person - $24.80/month ☐ Family - $37.20/month
☐ DELTA DENTAL GROUP #2 **SEE NOTE!** PPO / 100% Plan	☐ 1 Person - $ 60.00/month ☐ 2 Person - $120.00/month ☐ Family - $158.00/month	** 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 www.deltadentalins.com to make sure your dentist is contracted with the PPO plan.	

	SOCIAL SECURITY NUMBER	LAST NAME (PRINT)	FIRST NAME	MI	DATE OF BIRTH
☐ Dental ☐ Vision ☐ Decline Dental ☐ Decline Vision					/ /

STREET ADDRESS	CITY	STATE	ZIP

	TELEPHONE NUMBER	E-MAIL ADDRESS
☐ MALE ☐ FEMALE	( )	

			LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	SOCIAL SECURITY NUMBER	DATE OF BIRTH
☐ Dental ☐ Vision ☐ Decline Dental ☐ Decline Vision	☐ Spouse ☐ Domestic Partner ☐ Male/Female	Date of Marriage:_____					/ /
☐ Dental ☐ Vision ☐ Decline Dental ☐ Decline Vision	☐ Son ☐ Daughter	☐ Totally Disabled (Y/N?)					/ /
☐ Dental ☐ Vision ☐ Decline Dental ☐ Decline Vision	☐ Son ☐ Daughter	☐ Totally Disabled (Y/N?)					/ /
☐ Dental ☐ Vision ☐ Decline Dental ☐ Decline Vision	☐ Son ☐ Daughter	☐ Totally Disabled (Y/N?)					/ /

☐ I understand it is my responsibility to notify my District once a dependent is no longer eligible due to divorce or over-age 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.

na DEDUCTION AUTHORIZATION: If applicable, I authorize my school district to deduct from my wages the required contribution.

☐ 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 coverage is subject to SISC III approval.

☐ 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

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 knowlingly and with intent to injure, defraud, or deceive the District, 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.)

Applicant Signature Required _____ Date _____