COBRA Benefits Enrollment/Change Form

Capistrano Unified School District belongs to the California Schools Benefits Trust (CSBT). Working collaboratively with California Schools Voluntary Employees Benefits Association (VEBA), CSBT provides health care benefits and related services that are effective, affordable and of the highest quality. The District, CSBT and VEBA are committed to helping you and your family be healthy and stay healthy. To make sure that your health plan selections will best meet the needs of you and your family, we encourage you to review the benefit summaries for each plan which are available on the district website at https://www.capousd.org/subsites/Insurance/.

WHAT YOU NEED TO KNOW

Section 1. Participant Enrollment Information *(ALL participants must complete Parts A, B and C of this section)*

- ☐ Fill in all the information requested *(Kaiser Permanente HMO members and UMR PPO plan members do NOT have to include a Primary Care Provider (PCP) name or number).*
- ☐ Check with your employer to determine if domestic partnership coverage is available.
- ☐ You can enroll your eligible dependents up to age 26.
- ☐ Proof of permanent disability is required for dependents over age 26.
- ☐ If you enroll in the Vision Plan, you must sign the Vision Plan box.

Section 2. Participant Signature Required for Binding Arbitration Agreement

- ☐ All participants must sign the Binding Arbitration agreement as a requirement of the plan you select.
- ☐ If you don't sign your health plan's Binding Arbitration agreement, your enrollment may be denied.
- ☐ Participants enrolling in a UHC Plan must review and sign the "Release of Medical Information" section.

IMPORTANT NOTES: If you enroll in the **Cigna HMO or UnitedHealthcare Performance HMO Plans:**

- ☐ You must select a Primary Care Provider — if you do not select a PCP, one will be assigned to you.

Additional notes for the UnitedHealthcare Performance HMO plan:

- ☐ This plan is open to current enrollees only - no new enrollments.
- ☐ You and any dependents must ALL enroll in the same network.
- ☐ You and each of your dependents will remain in your selected network and HMO plan for the ENTIRE plan year.
- ☐ You and your dependents can choose separate Medical Groups as long as they are in the same network.

REASON FOR THIS APPLICATION:

☐ OPEN ENROLLMENT
☐ NEW HIRE _____ (DATE OF HIRE)
☐ REHIRE/RETURN FROM LEAVE _____ (DATE OF HIRE)
☐ ADD DEPENDENT: MARRIAGE
_____ (DATE OF MARRIAGE)
☐ ADD DEPENDENT: BIRTH/ ADOPTION
_____ (DATE OF BIRTH/ ADOPTION)
☐ ADD DEPENDENT: OTHER QUALIFYING EVENT
_____ (LIST QUALIFYING EVENT)

☐ CONTACT INFO CHANGE
☐ NAME CHANGE
☐ DELETE DEPENDENT
☐ DELETE ENROLLMENT
☐ COBRA
☐ MEDICARE ELIGIBLE
☐ QMCSO

EMPLOYER USE ONLY:
EFFECTIVE DATE: _____
DISTRICT ID #: _____
☐ ACTIVE
☐ RETIRED
☐ LOA
☐ COBRA
CLASSIFICATION: _____

INDICATE YOUR PLAN SELECTION BELOW:

MEDICAL PLAN:
☐ CIGNA SELECT HMO
☐ KAISER $15 HMO
☐ KAISER $25/$45 HMO - LOW OPTION
☐ UNITEDHEALTHCARE HARMONY HMO $10
☐ UNITEDHEALTHCARE SIGNATUREVALUE ALLIANCE HMO $10
☐ UNITEDHEALTHCARE SIGNATUREVALUE ALLIANCE HMO - LOW OPTION
☐ UNITEDHEALTHCARE JOURNEY HARMONY HMO w/ HRA
☐ UMR SELECT PLUS PPO
☐ UNITEDHEALTHCARE PERFORMANCE HMO NETWORK 2 **(NO NEW ENROLLMENTS)**

DENTAL PLAN:
☐ DELTA DENTAL HMO (DELTACARE USA)
☐ DELTA DENTAL PPO

VISION PLAN:
☐ VSP VISION

Signature

COBRA PARTICIPANT INFORMATION:

NAME:		☐ MALE ☐ NON-BINARY ☐ FEMALE
MAILING ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE: ☐ HOME ☐ MOBILE	WORK TELEPHONE:	BIRTH DATE *(MM/DD/YY)*:
SOCIAL SECURITY NUMBER *(SSN)*:	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER	
EMAIL ADDRESS:	PERSONAL EMAIL:	

COBRA PARTICIPANT INFORMATION CONTINUED:

MEDICAL PRIMARY CARE PHYSICIAN* - FIRST AND LAST NAME *(UNITEDHEALTHCARE AND CIGNA HMO PLANS ONLY):* *PCP FIRST AND LAST NAME:* *PCP / GROUP ID:*	EXISTING PATIENT: ☐ YES ☐ NO
DENTAL PROVIDER* NAME AND FACILITY ID# *(DELTACARE USA HMO PLAN ONLY):*	EXISTING PATIENT: ☐ YES ☐ NO

***WHEN A VALID PROVIDER NAME AND ID IS NOT SELECTED ON A HMO PLAN, THE CARRIER WILL SELECT ONE FOR YOU AND YOUR ELIGIBLE DEPENDENTS.**

DEPENDENT INFORMATION:

NAME *(LAST, FIRST, MIDDLE INITIAL)*	SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YY)	SEX M/F/ NB	MEDICAL COVERAGE (CHECK IF YES)	FIRST AND LAST NAME OF PCP (UHC AND CIGNA HMO ONLY)	EXISTING PATIENT (CHECK IF YES)	DENTAL COVERAGE	DENTAL PROVIDER NAME AND ID# (HMO ONLY)	EXISTING PATIENT (CHECK IF YES)	VISION COVER-AGE (CHECK IF YES)
SPOUSE/DOMESTIC PARTNER				☐ ADD ☐ DELETE	PCP NAME: PCP ID:	☐ YES	☐ ADD ☐ DELETE		☐ YES	☐ ADD ☐ DELETE
CHILD				☐ ADD ☐ DELETE	PCP NAME: PCP ID:	☐ YES	☐ ADD ☐ DELETE		☐ YES	☐ ADD ☐ DELETE
CHILD				☐ ADD ☐ DELETE	PCP NAME: PCP ID:	☐ YES	☐ ADD ☐ DELETE		☐ YES	☐ ADD ☐ DELETE
CHILD				☐ ADD ☐ DELETE	PCP NAME: PCP ID:	☐ YES	☐ ADD ☐ DELETE		☐ YES	☐ ADD ☐ DELETE
CHILD				☐ ADD ☐ DELETE	PCP NAME: PCP ID:	☐ YES	☐ ADD ☐ DELETE		☐ YES	☐ ADD ☐ DELETE

IF ANY DEPENDENTS LISTED ABOVE HAVE AN ADDRESS THAT IS DIFFERENT FROM THE PARTICIPANT, PLEASE LIST BELOW:

NAMES AND CORRESPONDING ADDRESS:

IF ANY DEPENDENTS ARE ALSO COVERED BY ANOTHER CAPISTRANO UNIFIED DISTRICT EMPLOYEE, PLEASE LIST NAME OF THAT EMPLOYEE:

PARTICIPANT SIGNATURE REQUIRED FOR ENROLLMENT/CHANGES

Based on the health plan you enroll in, you must sign the plan's Binding Arbitration agreement for your enrollment to be effective.

• Sign **A** below for **Kaiser Plan** • Sign **B** below for **UnitedHealthcare Plan** • Sign **C** below for **Cigna HealthCare Plan** • Sign **D** below for **Delta Dental Plan**

A: Kaiser Foundation Health Plan Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a Kaiser Permanente Plan)*

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

_____ _____ _____

Participant Signature Required for Kaiser Permanente Plan **Participant Name** (please print) **Date** (month/day/year)

* Disputes arising from fully-insured Kaiser Permanente Insurance Company (KPIC) coverage are not subject to binding arbitration 1) the Preferred Provider Organization (PPO) and the Out-of Network portion of the Point of Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out of Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

B: UnitedHealthcare Plan Members Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a UnitedHealthcare Plan)*

UnitedHealthcare Binding Arbitration Agreement

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

YOUR SIGNATURE

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

_____ _____ _____

Participant Signature Required for UnitedHealthcare Plan **Participant Name** (please print) **Date** (month/day/year)

SECTION B CONTINUED (UHC PLAN MEMBERS MUST SIGN "AUTHORIZATION TO RELEASE MEDICAL INFORMATION" BELOW)

HIV Disclaimer

"California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage."

Legal Entities Disclaimer

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by UnitedHealthcare Insurance Company, United HeathCare Services, Inc., PacifiCare Health Plan Administrators, Inc., Prescription Solutions or Optum Health Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

Authorization to Release Medical Information

I authorize UnitedHealthcare Insurance Company and its affiliates ("UnitedHealthcare and Affiliates") to obtain, use and disclose my medical, claim or benefits records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care providers, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearing house, and any of their affiliates, representatives or business associates who may be in possession of my confidential health information, to disclose my information to UnitedHealthcare and Affiliates. I understand the purpose of the disclosure and use of my information is to allow UnitedHealthcare and affiliates to make decisions regarding eligibility, enrollment and risk rating. I understand this authorization is voluntary and I may refuse to sign authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare and Affiliates representative in writing except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person to obtain and use may be redisclosed (with the exception of HIV/AIDS health information) and no longer protected by federal privacy regulations except as prohibited by state law. This authorization, unless revoked earlier, expires 30 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request that indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize the required premium contributions to be deducted from earnings. I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments. UnitedHealthcare is only seeking to collect information about the current health status of those persons listed on the application. You should not include any genetic information. Please do not include any family medical history information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

_____	_____	_____
Participant Signature Required for UnitedHealthcare Plan	**Participant Name** (please print)	**Date** (month/day/year)

C. Cigna HealthCare Binding Arbitration Agreement (Read and sign this section ONLY if you enroll in a Cigna Plan)

Cigna HealthCare Binding Arbitration Agreement

I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract. In addition, I agree to the following authorizations:

CALIFORNIA RESIDENTS ONLY: Cigna HealthCare uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and Cigna HealthCare (including any of their agents, successors- or predecessors-in-interest, employees or providers).

PROVISIONS
"Cigna HealthCare" refers to various operating subsidiaries of Cigna Corporation. Products and services are provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, Cigna Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING
Any person who, knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and subject to fines and confinement in state prison.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS
I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS
By allowing an individual to enroll in the Insurance Plan other than during the Open Enrollment period, Cigna HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an Open Enrollment period, Cigna HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

_____	_____	_____
Participant Signature Required for Cigna HealthCare Plan	**Participant Name** (please print)	**Date** (month/day/year)

D: Delta Dental Plan Binding Arbitration Agreement *(Read and sign this section ONLY if you enroll in a Delta Dental Plan)*

Delta Dental Plan Arbitration Agreement

I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract. In addition, I agree to the following authorizations:

I Deduction Authorization: I hereby authorize Capistrano Unified School District to pay the dental benefits premiums for me and my eligible dependents (if applicable) to the plan checked above until changed or revoked by me in writing. I also authorize Capistrano Unified School District to deduct from my salary the amount necessary, if any, to pay for my dental coverage not paid by the district and to transmit the same to the above-named plan.

II Authorization to Obtain or Release Medical Information (Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et.seq. of the California Civil Code): I hereby authorize my dentist, physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish an agent, designee or representative of the dental plan in which I am enrolling as indicated above, any and all records pertaining to medical/dental history, services rendered or treatment given to anyone enrolled hereunder or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize such carriers or their agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical/dental information obtained, if such disclosure is necessary, to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to allow the processing of any claim.

III Arbitration Agreement: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled eligible dependent) and Delta Dental PPO Plan or Delta Care USA Dental whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

IV Dependent Coverage: I have read and understand the provisions on this form pertaining to dependents who are eligible to be included in my dental coverage. I hereby certify that the individuals listed on this enrollment form, if any, meet those provisions. Additionally, I understand that dependents not listed on this enrollment form may be added only by submitting appropriate forms to the Insurance Department within 30 days of the date the dependent becomes eligible for coverage or during the annual Open Enrollment period held in the fall.

☐ *By checking this box, I am indicating that I have carefully read the above "Binding Arbitration" agreement and agree to its terms.*

_____	_____	_____
Participant Signature Required for Delta Dental Plan	**Participant Name** (please print)	**Date** (month/day/year)