

**STSIG ENROLLMENT FORM - Type or print clearly in black ink Revised 8/2018**

**SECTION I: SELECTED COVERAGE**

ENROLLMENT REASON:  NEW HIRE  EMPLOYEE STATUS CHANGE TO  RETIREE <65  RETIREE >65  COBRA

JOB TITLE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ HIRE DATE: \_\_\_\_\_ DISTRICT APPROVED INITIALS: \_\_\_\_\_

DISTRICT NAME (DO NOT ABBREVIATE) \_\_\_\_\_ EMPLOYEE GROUP (BARGAINING UNIT) \_\_\_\_\_  Full-time  Part-time

Certificated  Classified  Management  Confidential  Active  Admin  Board Member

**This row to be completed by STSIG only** Medical Group Number \_\_\_\_\_ Dental Group Number \_\_\_\_\_ Vision Group Number \_\_\_\_\_

**SECTION II: EMPLOYEE / APPLICANT INFORMATION - REQUIRED**

MEDICAL  Decline

DENTAL  Decline

VISION  Decline

SOCIAL SECURITY NO. \_\_\_\_\_ LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  MALE  FEMALE

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NO. ( ) \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_ DO YOU HAVE MEDICARE A&B COVERAGE?  YES  NO If yes, attached copy of card Medicare Number: \_\_\_\_\_

**MEDICAL PLAN OPTIONS – CHOOSE ONE**

80C  80G  80K  80M  HSA-A  HSA-B  HSA - Min.Value  Decline  Dental Plan

**SECTION III: DEPENDENT INFORMATION**

MEDICAL  Decline

DENTAL  Decline

VISION  Decline

Spouse  Domestic Partner

LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

Gender  Male  Female DATE OF BIRTH \_\_\_\_\_ TOTALLY DISABLED?  YES  NO DO YOU HAVE MEDICARE A&B COVERAGE?  YES  NO Medicare Number: \_\_\_\_\_ Attach copy of Medicare Card

MEDICAL  Decline

DENTAL  Decline

VISION  Decline

SON  DAUGHTER

LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ TOTALLY DISABLED?  YES  NO

MEDICAL  Decline

DENTAL  Decline

VISION  Decline

SON  DAUGHTER

LAST NAME (PRINT) \_\_\_\_\_ FIRST NAME (PRINT) \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ TOTALLY DISABLED?  YES  NO

**\*\* Dependent enrollments require proof of dependence – please attached proof with enrollment form.**

- 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 STSIG if claims were paid on behalf of non-eligible individuals.
- DEDUCTION AUTHORIZATION:** If applicable, I authorize my school district to deduct from my wages the required contribution. **Pre-tax  After-tax**
- 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:** California 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 STSIG 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 knowingly and with intent to injure, defraud, or deceive the district, STSIG, 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 STSIG AND/OR 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 STSIG AND/OR SISC III ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. STSIG AND/OR 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

