Poway Unified School District
2019 Retiree Benefit Enrollment Form

This form must be completed to make changes during the annual Open Enrollment period;
within 30 days of benefit eligibility or to make changes due from an IRS qualified mid-year event.
Failure to complete and return this form within the specified time-frame may result in denial of coverage/changes.
This form will replace any and all information previously on file.

Retiree ID:	**Name:**		**Retirement Date:**
SS#	**Date of Birth:**		**Union:**
Email Address	**Home Phone:**		**Cell Phone:**
Street Address:	**City:**	**State:**	**Zip:**
Status Change Effective:	**Effective Date:**		
Reason For Change:			

Plan Options

Select your plans by checking the box next to the plan's coverage level. Please refer to your Bargaining Unit for District Contribution details. Dependent coverage may be elected separately. If you are electing **Kaiser Sr. Advantage** you must also complete a carrier specific enrollment form as required by CMS. Please contact the Insurance Benefits Department prior to Medicare eligibility. ***PLEASE NOTE:*** *As a Retiree, once you drop a line of coverage you are no longer eligible to enroll in that coverage.*

Medical Plans	Coverage Level
Kaiser Permanente HMO (61KHR) (104206-0000)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
Aetna Value Network (61AVNR) (without Scripps)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
Aetna Full Network (61AFNR) (includes Scripps)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
Aetna OAMC (PPO) (61AOAR)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents

Medicare Medical Plans	Coverage Level
Aetna EPO (61AEPR)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
Aetna OAMC (PPO) (61AOAR)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
Kaiser Permanente Senior Advantage (61KSRR) (104206-0001)	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents

Dental Plans	Coverage Level
Delta Dental PPO (61DDR) 6779-0002	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents
MetLife DHMO* 0216420-0002	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents

Vision Plan	Coverage Level
MES Vision (61VSNR) 92-005	◯ Employee Only ◯ Employee + 1 Dependent ◯ Employee + 2 or more Dependents

FOR OFFICE USE ONLY

Entered by: _____ Audited by: _____

Retiree Empl Rec: _____ Position #: _____ YOS: _____ U65 _____ O65_____

❑ BB _____ ❑PS _____ ❑ 61MES _____ ❑ Ded Override ❑ RTB Addl. Pay ❑ AP Override ❑ PDS/Coupons EE% _____ ER%_____

Name:	Retiree ID:	Effective Date:

Retiree/Dependent Information

FOR ALL ENROLLMENTS:

Enter information for yourself and any eligible dependents you are enrolling in Medical, Dental, and/or Vision.

A PROVIDER NAME/GROUP IS REQUIRED FOR AETNA HMO/METLIFE DENTAL HMO ENROLLMENTS ONLY.

For information on how to choose/find a provider/group, please refer to the Benefits Information Guide.

Retiree

Relationship: Self	Name:	DOB:	Gender:

Social Security #:	Disabled? ☐ Yes ☐ No	Enroll in Medical? ☐ Yes ☐ No	Enroll in Dental? ☐ Yes ☐ No	Enroll in Vision? ☐ Yes ☐ No

Physician Name/Primary Office # (Aetna Only):	Current Patient? ☐ Yes ☐ No	Dental Facility ID (Metlife HMO Only):

Dependent 1

Relationship:	Name:	DOB:	Gender:

Social Security #:	Disabled? ☐ Yes ☐ No	Enroll in Medical? ☐ Yes ☐ No	Enroll in Dental? ☐ Yes ☐ No	Enroll in Vision? ☐ Yes ☐ No

Physician Name/Primary Office # (Aetna Only):	Current Patient? ☐ Yes ☐ No	Dental Facility ID (Metlife HMO Only):

Dependent 2

Relationship:	Name:	DOB:	Gender:

Social Security #:	Disabled? ☐ Yes ☐ No	Enroll in Medical? ☐ Yes ☐ No	Enroll in Dental? ☐ Yes ☐ No	Enroll in Vision? ☐ Yes ☐ No

Physician Name/Primary Office # (Aetna Only):	Current Patient? ☐ Yes ☐ No	Dental Facility ID (Metlife HMO Only):

Dependent 3

Relationship:	Name:	DOB:	Gender:

Social Security #:	Disabled? ☐ Yes ☐ No	Enroll in Medical? ☐ Yes ☐ No	Enroll in Dental? ☐ Yes ☐ No	Enroll in Vision? ☐ Yes ☐ No

Physician Name/Primary Office # (Aetna Only):	Current Patient? ☐ Yes ☐ No	Dental Facility ID (Metlife HMO Only):

Dependent 4

Relationship:	Name:	DOB:	Gender:

Social Security #:	Disabled? ☐ Yes ☐ No	Enroll in Medical? ☐ Yes ☐ No	Enroll in Dental? ☐ Yes ☐ No	Enroll in Vision? ☐ Yes ☐ No

Physician Name/Primary Office # (Aetna Only):	Current Patient? ☐ Yes ☐ No	Dental Facility ID (Metlife HMO Only):

Medicare Enrollment Information

If you or your dependents are Medicare eligible, please complete this section.

Name:	Medicare ID#	Part A Eff:	Part B Eff:
Name:	Medicare ID#	Part A Eff:	Part B Eff:
Name:	Medicare ID#	Part A Eff:	Part B Eff:

Aetna Health of California Inc.

Conditions of Enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining healthinsurance coverage.

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO: Aetna Health of California Inc.
   - Aetna OAMC (PPO): Open Access Managed Choice
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions, except with regards to health status related factors, may result in future claims being denied and the policy or my coverage under the policy being reevaluated, as of the effective date, for eligibility and rating purposes.
3. I understand and agree that this enrollment form may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Form, including those involving mental health, substance abuse and AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. I understand that this authorization is provided under state law, and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization is valid for term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery , all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist,hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents and when enrolled for medical coverage, any pre-existing conditions for my spouse, dependents or myself may not be covered for 6 months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Misrepresentation

8. Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this California Employee Enrollment/Change Form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1, and I am working full time at least 30 hours per week for this employer at the regular place of business.

CA HMO ENROLLEES - NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP WILL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.

I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

☐ I AM ENROLLING FOR COVERAGE: ***Employee Signature*** **X**	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***

DMHC Written Notice of Availability of Language Assistance

HMO based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.

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.

_____ _____

Signature Required for Kaiser Permanente Plan Date

PUSD Benefit Acknowledgment Agreement

Release of Information: I authorize any physician, health care practitioner, hospital or other health care facility, clinic, health care service plan, or any other person or entity to release to any health care plan provider of the Poway Unified School District, a health care service plan, a self-insurer, or any insurance company, or its designee, all medical or personal information related to myself or any covered dependent, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: Diagnosis or treatment; Payment of health services rendered; Billing, claims management, medical data processing, or other administrative function of the health plan in which I am enrolled through the District; Peer review, including reviewing the competence or qualifications of health care professionals; Utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; Handling of member grievances or appeals, external independent review, or other health dispute resolution; Coordination of care with providers of health care or other health care service plans; Administering the health benefit plan; Chronic disease management programs, to monitor or administer care of a covered benefit; to verify my participation in other healthcare coverage if I elected to Opt-Out of sponsored benefit and other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my health plan provider through the Poway Unified School District.

Changes in Coverage: If you or your dependents experience a qualifying event resulting in a change in family status, you must contact the Insurance Benefits Department to request an enrollment change within 30 days from the start of the qualifying event. If you do not request the enrollment change within 30 days, you must wait until the next District Open Enrollment period or experience an additional qualifying event before you will be permitted to make a change to your existing enrollment.

Health Insurance Portability and Accountability - Special Enrollment Rights: If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll your dependents, provided that you request enrollment within 30 days after the qualifying event occurs. Dependent children eligible up to age 26.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. A Notice of Privacy Practices will be included in the Evidence of Coverage booklets and is available on the carrier websites or by calling Customer Service.

Retiree's Authorization, Release and Signature: I understand that I must meet the eligibility requirements of my elections as indicated on this Benefit Enrollment Form. Submission of this Benefit Enrollment Form is not confirmation that eligibility requirements have been met or verified. **I have read**, understand and agree to the terms and conditions set forth in this Benefit Enrollment Form, including the Release of Information, Binding Arbitration, Changes in Coverage and Medical Waiver, if applicable.

I certify that the information on this form is complete and correct. I understand that I must meet the eligibility requirements of each benefit plan that I have elected. I understand that submission of this Enrollment Form is not a confirmation that eligibility requirement have been met or verified. I also certify that the names of all dependents listed above for medical, dental, and vision coverage are my eligible dependents. I agree to submit payment directly to Poway Unified School District on a quarterly, annual, or semi-annual basis. **I certify that I have read, understand, and agree to the terms outlined on this Benefit Election Form.**

Print Name _____

Signature _____ **Date** _____