SISC
Self-Insured Schools of California
Schools Helping Schools

SISC CompanionCare/PPO EGWP Rx Enrollment Form for Medical and Rx Benefits

Welcome to SISC!

We look forward to serving your needs

Instructions to complete packet

- ✓ Contents of packet
  - o Enrollment Form (2 pages)
  - o Declaration of Prior Prescription Drug Coverage (2 pages)
  - o Notice of Privacy Practices (4 pages)

- ✓ **Each individual** person enrolling must complete the following:

  - o Enrollment Form
    - ▪ Complete all blank fields
    - ▪ Date and sign
    - ▪ Provide copy of Medicare card with Medicare Beneficiary Identifier (MBI). Medicare cards with social security numbers can no longer be accepted
    - ▪ If enrolling spouse for the first time, a copy of the prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out)
    - ▪ For newly married couples where prior year tax return is not available a marriage certificate will be accepted
  - o Declaration of Prior Prescription Drug Coverage
    - ▪ Page 1 "Dates of Coverage"
    - ▪ the "from" date will be the date the member became eligible for Medicare

- ✓ Retain the Notice of Privacy Practices for your records

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REQUIRED INFORMATION	
District Use Only	
District Name:	
❑ **SISC bills District**	❑ **SISC bills Retiree**
Medical Group No.	**Effective Date**
Dental Group No.	**Vision Group No.**
Bargaining Unit:	

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❑ I am the Retiree or

❑ I am the Spouse or Domestic Partner (provide name and SSN of the retiree) _____

Applicant Name: _____
(as it appears on Medicare card) (Last) (First) (Middle Initial)

Social Security Number: _____ Date of Birth: _____
(MM / DD / YYYY)

❑ Male ❑ Female

Email address: _____ Phone Number: _____

Home Address:

_____
Street, Apt. No., Suite No. City State Zip

If transferring from another group or plan, indicate:

I am covered under Medicare for: ❑ Hospital Part A ❑ Medical Part B ❑ Part D Prescription Drugs

I am not currently covered under Medicare Parts A & B ❑ I will be covered effective _____

Medicare ID Number Required: _____
(Please attach a photocopy of your Medicare card)

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Applicant Name: _____
(Last) (First) (Middle Initial)

I understand that the following conditions apply as a part of this coverage:

1. Continuous enrollment in Medicare A&B is required.
2. I understand SISC will automatically enroll member(s) in Medicare Part D.
3. I understand if my doctor does not accept Medicare Assignment, I will be responsible for the difference between the Medicare allowable charge and the doctor's billed charges.
4. This application form, a copy of the applicant's Medicare card and Declaration of Prior Prescription Drug Coverage **MUST** be received by SISC **45 calendar days** in advance of the requested effective date.
5. To CANCEL this coverage, the SISC Disenrollment form MUST be completed and received by SISC 45 calendar days in advance of the requested termination date. Both Medical and Prescription drug benefits will be canceled.
6. I understand it will be my responsibility as the applicant to notify Medicare at 1-800-Medicare (1-800-633-4227) within 63 days after coverage ends to select a new Medicare Part D plan.
7. I understand I can only be in one Medicare prescription drug plan at a time – if I am currently enrolled in a Medicare Prescription Drug Plan other than Navitus MedicareRx, my enrollment in Navitus MedicareRx (PDP) will end that enrollment.

Please Read and Sign Below

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: _____

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: _____

Member Name: _____

Address: _____

_____

Phone: _____

Member ID: <Member ID>

Medicare Health Insurance Claim # or your MBI: _____

(From red, white and blue Medicare card)

Name of Medicare Prescription Drug Plan: _____

Please check all boxes that apply to you.	**Dates of Coverage (month/year)**
☐ I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP). Name: _____	From: _____ To: _____
☐ I never had creditable* drug coverage	

* "Creditable" means that your prior coverage met Medicare's minimum standards.

Please complete the signature section on the following page.

Please complete this section:

"To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Navitus MedicareRx (PDP) by Medicare."

Signature: _____

Date: *(month/day/year):* _____

If you are the representative, you must provide the following information:

Name: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____- _____

Relationship to Member: _____