SISC
Self-Insured Schools of California
Schools Helping Schools

SISC Enrollment Form for following plans:

- **PPO Retiree 65+ with Medicare A&B (EGWP Rx)**
- **CompanionCare – Medicare A&B Supplement (Part D Rx)**

Welcome to SISC!

We look forward to serving your needs

✓ **Each individual (member)** enrolling must complete the following:

- **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 are no longer accepted.
  - Dependent documentation is required when enrolling a spouse/domestic partner for the first time.
    - **Spouse**: Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out). A marriage certificate will be accepted for newly married couples where prior year tax return is unavailable.
    - **Domestic Partner**: Certificate of Registered Domestic Partnership issued by State of California
- **Declaration of Prior Prescription Drug Coverage**
  - On page 1, under "Dates of Coverage," please use the date the member became eligible for Medicare in the "from" section. This informs Navitus of the date the member became eligible for Medicare, not necessarily the date enrolled in 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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Please choose one:

❑ I am the Retiree

❑ I am the Spouse or Domestic Partner (provide name and SSN of the retiree). Separate enrollment form required.

Retiree name	Retiree SSN

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

I am currently covered under Medicare for:
❑ Hospital Part A (Date):_____ ❑ Medical Part B (Date):_____

I am not currently covered under Medicare Parts A&B. It will be effective on the following dates:
❑ Hospital Part A (Date):_____ ❑ Medical Part B (Date):_____

Medicare Beneficiary Identifier (MBI) Required: _____
(Please attach a photocopy of your Medicare card)

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- **PPO Retiree 65+ with Medicare A&B (EGWP Rx)**
- **CompanionCare – Medicare A&B Supplement (Part D Rx)**

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 terminate 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: _____

NOTICE OF PRIVACY PRACTICES
FOR THE USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 3, 2006
Anyone has the right to ask for a paper copy of this Notice at any time.

Q. Why are you providing this Notice to me?
A. The SISC Health Benefits Plan is required by federal law, the Health Insurance Portability and Accountability Act (HIPAA), to make sure that your Protected Health Information (PHI) is kept private. This law applies to the health benefits offered through SISC, including SISC Flex, the Health Reimbursement Arrangements (SISC HRA) and the Health Savings Account (SISC HSA). We must give you this Notice of our legal duties and Privacy Practices with respect to your PHI. We are also required to follow the terms of the Notice that is currently in effect. PHI includes information that we have created or received about your past, present, or future health or medical condition that could be used to identify you. It also includes information about medical treatment you have received and about payment for health care you have received. We are required to tell you how, when, and why we use and/or share your Protected Health Information (PHI).

Q. How and when can you use or disclose my PHI?
A. HIPAA and other laws allow or require us to use or disclose your PHI for many different reasons. We can use or disclose your PHI for some reasons without your written agreement. For other reasons, we need you to agree in writing that we can use or disclose your PHI. We describe in this Notice the reasons we may use your PHI without getting your permission. Not every use or disclosure is listed, but the ways we can use and disclose information fall within one of the descriptions below.

So you can receive treatment. We may use and disclose your PHI to those who provide you with health care services or who are involved in your care. These people may be doctors, nurses, and other health care professionals. For example, if you are being treated for a knee injury, we may give your PHI to the people providing your physical therapy. We may also use your PHI so that health care can be offered or provided to you by a home health agency.

To get payment for your treatment. We may use and disclose your PHI in order to bill and get paid for treatment and services you receive. For example, we may give parts of your PHI to our billing or claims department or others who do these things for us. They can use it to make sure your health care providers are paid correctly for the health care services you received under a health plan.

To operate our business. We may use and disclose your PHI in order to administer our health plans. For example, we may use your PHI in order to review and improve the quality of health care services you receive. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are obeying the laws that affect us. Another time when we may provide PHI to other organizations is when we ask them to tell us about the quality of our health plans and how we operate our business. Before we share PHI with other organizations, they must agree to keep your PHI private.

To meet legal requirements. We share PHI with government or law enforcement agencies when federal, state, or local laws require us to do so. We also share PHI when we are required to in a court or other legal proceeding. For example, if a law says we must report private information about people who have been abused, neglected, or are victims of domestic violence, we share PHI.

To report public health activities. We share PHI with government officials in charge of collecting certain public health information. For example, we may share PHI about births, deaths, and some diseases. We may provide coroners, medical examiners, and funeral directors information that relates to a person's death.

For health oversight activities. We may share PHI if a government agency is investigating or inspecting a health care provider or organization.

For purposes of organ donation. Even though the law permits it, we do not share PHI with organizations that help find organs, eyes, and tissue to be donated or transplanted.

For research purposes. We do not use or disclose your PHI in order to conduct medical research.
To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement or people who may be able to stop or lessen the harm.

For specific government functions. We may share PHI for national security reasons. For example, we may share PHI to protect the president of the United States. In some situations, we may share the PHI of veterans and people in the military when required by law.

For workers' compensation purposes. We may share PHI to obey workers' compensation laws.
For information about health-related benefits or services. We may use PHI to give you information about other health care treatment services, or benefits.
A plan amendment has been adopted to protect your PHI as required by law. The plan amendment allows PHI to be shared with the plan sponsor (SISC III Board of Directors) for purposes of treatment, payment, health care operations and for other reasons related to the administration of the SISC Health Benefits Plan.

Other Uses and Disclosures Require Your Prior Written Agreement. In other situations, we will ask for your written permission before we use or disclose your PHI. You may decide later that you no longer want to agree to a certain use of your PHI for which we received your permission. If so, you may tell us that in writing. We will then stop using your PHI for that certain situation. However, we may have already used your PHI. If we had your permission to use your PHI when we used it, you cannot take back your agreement for those past situations.

Q. Will you give my PHI to my family, friends, or others?
A. We may share medical information about you with a friend or family member who is involved in or who helps pay for your medical care when you are present. For example, if one of our home health nurses or case manager's visits you at your home or in the hospital and your mother is with you, we may discuss your PHI with you in front of her. We will not discuss your PHI with you when others are present if you tell us not to.

In order to enroll you in a health plan, we may share limited PHI with your employer or other organizations that help pay for your membership in the plan. However, if your employer or another organization that pays for your membership asks for specific PHI about you, we will get your permission before we disclose your PHI to them.

There may be a situation in which you are not present or you are unable to make health care decisions for yourself. Then we may use or share your PHI if professional judgment says that doing so is in your best interests. For example, if you are unconscious and a friend is with you, we may share your PHI with your friend so you can receive care.

Q. What are my rights with respect to my PHI?
A. You have the right to ask that we limit how we use and give out your PHI. You also have the right to request a limit on the PHI we give to someone who is involved in your care or helping pay for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you had. We will consider your request. However, we are not required to agree to the request. If we accept your request, we will put any limits in writing. We will honor these limits except in emergency situations. You may not limit the ways we use and disclose PHI when we are required to make the use or disclosure.

You have the right to ask that we send your PHI to you at an address of your choice or to communicate with you in a certain way if you tell us that this is necessary to protect you from danger. You must tell us in writing what you want and that the reason is you could be put in danger if we do not meet your request. For example, you may ask us to send PHI to your work address instead of your home address. You may ask that we send your PHI by e-mail rather than regular mail.

You have the right to look at or get copies of your PHI that we have. You must make that request in writing. You can get a form to request copies or look at your PHI by calling the SISC Privacy Officer. If we do not have your PHI, we will tell you how you may be able to get it. We will respond to you within 30 days after we receive your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, the reasons we are denying your request. We will also explain your right to have our denial reviewed.

If you ask for a copy of your PHI, we will charge you a reasonable fee based on the cost of copying and postage. We can send you your PHI, or if you request, we may send you a summary or general explanation of your PHI if you agree to the cost of preparing and sending it.
You have the right to get a list of instances in which we have given out your PHI. The list will not include: a) disclosures we made so you could get treatment; b) disclosures we made so we could receive payment for your treatment; c) disclosures we made in order to operate the Plan; d) disclosures made directly to you or to people you designated; e) disclosures made for national security purposes f) disclosures made to corrections or law enforcement personnel; g) disclosures we made before we sent you this Notice; or h) disclosures we made when we had your written permission.

We will respond within 60 days of receiving your written request. The list we give you can only include disclosures made after April 14, 2003, the date this Notice became effective. We cannot provide you a list of disclosures made before this date. You may request a list of disclosures made the six years (or fewer) preceding the date of your request. The list will include a) the date of the disclosure; b) the person to whom PHI was disclosed (including their address, if known); c) a description of the information disclosed; and d) the reason for the disclosure. We will give you one list of disclosures per year for free. If you ask for another list in the same year, we will send you one if you agree to pay the reasonable fee we will charge for the additional list.

You have the right to ask us to correct your PHI or add missing information if you think there is a mistake in your PHI. You must send us your request in writing and give the reason for your request. You can get a form for making your request by calling the SISC Privacy Officer. We will respond within 60 days of receiving your written request. If we approve your request, we will make the change to your PHI. We will tell you that we have made the change. We will also tell others who need to know about the change to your PHI.
We may deny your request if your PHI is a) correct and complete, b) not created by us, c) not allowed to be disclosed, or d) not part of our records. If we deny your request, we will tell you the reasons in writing. Our written denial will also explain your right to file a written statement of disagreement. You have the right to ask that your written request, our written denial, and your statement of disagreement be attached to your PHI anytime we give it out in the future.

Q. How may I complain about your Privacy Practices?
A. If you think that we may have violated your Privacy rights, you may send your written complaint to the address shown at the bottom of this notice. You also may make a complaint to the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint about our Privacy Practices.

Q. How will I know if my rights described in this Notice change?
A. We reserve the right to change the terms of this Notice and our Privacy Policies at any time. Then the new Notice will apply to all your PHI. If we change this Notice, we will put the new Notice on our website at and mail a copy of the new Notice to our subscribers (but not to dependents).

Q. Who should I contact to get more information or to get a copy of this Notice?
A. For more information about your Privacy rights described in this notice, or if you want another copy of the Notice, please visit our website where you can download the Notice. You may also write us at Self-Insured Schools of California, 2000 K Street, Bakersfield, CA 93301. Further information may also be obtained by calling SISC's Privacy Officer at (661) 636-4887.

ANNUAL NOTICE: Women's Health and Cancer Rights Act (WHCRA)
Your Plan is required to provide you annually with the following notice, which applies to breast cancer patients who elect to have reconstructive surgery in connection with a mastectomy.
Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in a manner determined in consultation with the attending physician and the patient, for:

• reconstruction of the breast on which the mastectomy was performed;

• surgery and reconstruction of the other breast to produce a symmetrical appearance; and

• prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a plan's deductibles, coinsurance or copayment provisions.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact your Plan Administrator.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: _____

Member Name: _____

Address: _____

_____

Phone: _____

Member ID: _____

Medicare Health Insurance Claim #: _____

(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 had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state. Name of SPAP: _____ If you are in an SPAP, what state do you live in: _____	From: _____ To: _____
☐ I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits).	From: _____ To: _____

☐	I had prescription drug coverage through my TRICARE or other military coverage.	From: _____ To: _____
☐	I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage.	From: _____ To: _____
☐	I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U).	From: _____ To: _____
☐	I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly).	From: _____ To: _____
☐	I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____	From: _____ To: _____
☐	I have/had extra help from Medicare to pay for my prescription drug coverage.	From: _____ To: _____
☐	I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: _____	From: _____ To: _____
☐	I never had creditable* drug coverage	

* “Creditable” means that your prior coverage met Medicare’s minimum standards.

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: _____