COLLEGE OF
MARIN

835 College Avenue
Kentfield, CA 94904
415 457.8811

Indian Valley Campus
415.457.8811
www.marin.edu

Offer of Health Insurance

(A response is required no later than two weeks from your date of offer)

As a variable hour, temporary, part-time or seasonal employee of the Marin Community College District (MCCD) for the 2018-2019 school year, you are being given the opportunity to purchase health insurance for you and your eligible children. A summary of the Blue Shield of California: 2-Tier Anchor Bronze Plan is available on our website at http://fiscal.marin.edu/benefits. If you should choose to enroll, you will be responsible for making monthly premium payments.

To request enrollment in this plan, you must submit the following items to the District's benefits office no later than two weeks from your date of offer.

- A completed and signed SISC III Enrollment Form (attached)
- Proof of eligibility for dependent children (birth certificates/adoption paperwork)
- Payment will be setup as a payroll deduction, unless otherwise instructed. If there is not enough payroll to cover the entire premium, a payment by check is required by the 25th of the month prior to the coverage month. If payment is not received by the 5th of the coverage month, your coverage will be terminated.

Make checks payable to: MCCD and returned to the District Benefits Office, 1800 Ignacio Blvd, Novato, CA 94949.

2018-2019 Monthly rates – Blue Shield of California: 2-Tier Anchor Bronze Plan

- Employee only: $ 630.00
- Employee and Children: $ 1,248.00

If your employment status ends at any time during the plan year, your coverage will be terminated the first of the month following and a COBRA Notice will be issued.

If you fail to provide the items required for enrollment, you and your dependent children will not be allowed to enroll until the next eligibility period.

Acknowledgement (Required)

I understand that I am being offered the opportunity to enroll in comprehensive health insurance coverage through my employment with the College of Marin. I understand that as of January 1, 2014, I am required by law to maintain minimum essential health insurance coverage for myself and my dependents, qualify for an exemption from the requirement, or pay a penalty tax. This ACA provision is known as the "individual mandate." Effective in 2019, the individual mandate is effectively repealed, as the penalty tax for noncompliance with the mandate will be reduced to $0.

______ I authorize payroll deductions for the coverage indicated until further notice. I understand that these rates are subject to change on an annual basis.

______ I have enclosed a check for the first month's premium. I understand that subsequent monthly payments by check are due in full by the 25th of the month prior to the coverage month and if payment is not received by the 5th of the coverage month, coverage will be terminated.

______ I decline coverage at this time. Further, I understand unless I experience a qualifying event (for example, marriage, divorce or an increase in hours worked above 130 hours per month), I will not be allowed to enroll in coverage or make changes to my selection until the next eligibility period.

Signature: ____ Date: ____

Print Name: ____ ID#: ____

SISC III ENROLLMENT FORM (DO NOT use for Kaiser members, use Kaiser Permanente enrollment form for Kaiser members)

(Type or print clearly in black ink)

SECTION I: SELECTED COVERAGE – REQUIRED (DISTRICT USE ONLY)

ENROLLMENT REASON: ☐ NEW HIRE ☐ OPEN ENROLLMENT ☐ EMPLOYEE STATUS CHANGE ☐ LOSS OF COVERAGE ☐ COBRA

QUALIFYING DATE: ____________ EFFECTIVE DATE: ____________ HIRE DATE: ______________ DISTRICT APPROVED INITIALS: __________

DISTRICT NAME (DO NOT ABBREVIATE)	EMPLOYEE GROUP (BARGAINING UNIT) ☐Certificated ☐Classified ☐Management	EMPLOYEE TYPE ☐ Full-Time ☐ Part-Time ☐ Variable/Temporary/Seasonal

MEDICAL GROUP NO.	DELTA DENTAL GROUP NO.	VISION GROUP NO.	LIFE GROUP NO.

SECTION II: EMPLOYEE / APPLICANT INFORMATION – REQUIRED

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	DATE OF BIRTH	☐ MALE ☐ FEMALE

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO.	E-MAIL ADDRESS	IPA (HMO ONLY–REQUIRED)	PCP (HMO ONLY–REQUIRED)	CURRENT PROVIDER? ☐ YES ☐ NO

MEDICARE COVERAGE If you are retired and entitled to Medicare and not enrolled, you may be subject to a premium surcharge.

ARE YOU RETIRED? ☐ YES ☐ NO
IF YES, DO YOU HAVE MEDICARE? ☐YES ☐NO (Copy of Medicare card required)
TOTALLY DISABLED? ☐ YES ☐ NO

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE? ☐ YES ☐ NO
(Copy of Medicare card required)

SECTION III: DEPENDENT INFORMATION Proof of eligibility required (i.e. birth/marriage/domestic partner certificate)

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SPOUSE ☐ DOMESTIC PARTNER GENDER ☐ M ☐ F	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

☐ MEDICAL ☐ DENTAL ☐ VISION

☐ SON ☐ DAUGHTER	LAST NAME (PRINT)		FIRST NAME (PRINT)		SOCIAL SECURITY NO.	
ELIGIBLE FOR OTHER HEALTH PLAN? ☐ YES ☐ NO	ENROLLED IN OTHER HEALTH PLAN? ☐ YES ☐ NO	DATE OF BIRTH	TOTALLY DISABLED? ☐ YES ☐ NO	IPA (HMO ONLY-REQUIRED)	PCP (HMO ONLY-REQUIRED)	IS THIS YOUR CURRENT PROVIDER? ☐ YES ☐ NO

- 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 SISC 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.
- **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 SISC 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, SISC, 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 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.)

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Applicant Signature Required Date