2025-2026 SAUSD Retiree Benefits

benefits

Open Enrollment Form

STAFF USE ONLY
Event Date: _____ Effective Date: 07/01/2025 Enrollment Change Type: ☐ Add ☐ Drop ☐ Other: _____

Section 1 - Employee Information

Print or type in dark ink and check each applicable box.

Last Name	First Name, Middle Name	Employee ID	Date of Birth	Social Security Number

Address	City	State	ZIP Code	Phone Number

Gender
☐ Female ☐ Male

Classification
☐ Certificated ☐ Classified ☐ Management

Marital Status
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Are you married to another SAUSD employee?
☐ Yes ☐ No
If yes, what is their SAUSD ID: _____

Section 2 - Selection of Plans

Select one medical and/or dental plan for you and your dependents. You and your dependents will be enrolled in the same plan(s). Provide all required documents for new dependents.

MEDICAL

☐ Kaiser Permanente HMO
Must sign Section 4

☐ Blue Shield Access+ HMO
Full HMO Network

☐ Blue Shield Trio ACO HMO
Narrow HMO Network

☐ Blue Shield Spectrum PPO

☐ Single (Employee Only)
☐ 2 Party (Employee +1 dependent)
☐ Family (Employee +2 or more dependents)

DENTAL

☐ Delta Care USA DHMO

☐ Delta Dental Incentive DPPO

☐ Delta Dental Network DPPO

☐ Single (Employee Only)
☐ 2 Party (Employee +1 dependent)
☐ Family (Employee +2 or more dependents)

REFUSAL OF COVERAGE
Complete this section if you are refusing coverage for you and/or your dependents.
I am refusing **MEDICAL** coverage for:
☐ Myself ☐ Spouse ☐ Dependents
I am refusing **DENTAL** coverage for:
☐ Myself ☐ Spouse ☐ Dependents

Section 3 - Dependent Information

Attach a separate sheet is necessary. Provide all required documents for new dependents.

EMPLOYEE

Last Name	First Name, Middle Name	**Blue Shield HMO Members ONLY** (Use this area to designate a primary care physician) PCP ID (Not your Blue Shield ID)	Physician Name

DEPENDENT 1

Last Name	First Name, Middle Name	**Blue Shield HMO Members ONLY** (Use this area to designate a primary care physician) PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relationship	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

DEPENDENT 2

Last Name	First Name, Middle Name	**Blue Shield HMO Members ONLY** (Use this area to designate a primary care physician) PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relationship	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

DEPENDENT 3

Last Name	First Name, Middle Name	**Blue Shield HMO Members ONLY** (Use this area to designate a primary care physician) PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relationship	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

DEPENDENT 4

Last Name	First Name, Middle Name	**Blue Shield HMO Members ONLY** (Use this area to designate a primary care physician) PCP ID (Not your Blue Shield ID)	Physician Name

Social Security Number	Date of Birth	Gender	Relationship	Enroll In
		☐ Female ☐ Male		☐ Dental ☐ Medical

Section 4 - Kaiser Foundation Health Plan Arbitration Agreement | Group: 132731 | Enrollment Unit: _____

Kaiser members must read and sign the following 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.

Kaiser Arbitration Agreement Signature _____ **Kaiser Arbitration Agreement Signature Date** _____

Section 5 - SAUSD Enrollment Form Signature (REQUIRED)

Your enrollment request will not be processed if this section is not signed.

By signing this form, I under my elections will remain in effect, if I remain eligible, or until I make another election during an enrollment period. I wish to enroll myself, and my eligible dependents I've listed on this form, into the selections I have chosen. I understand that I am responsible for informing the District of any eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I certify, under penalty of perjury, that the above information in true and accurate to the best of my knowledge.

SAUSD Enrollment Form Signature _____ **SAUSD Enrollment Form Signature Date** _____

Keep a copy of this form for your records