

U.A. LOCAL 159 HEALTH AND WELFARE FUND ENROLLMENT FORM

4160 Dublin Blvd. Suite 400 ♦ Dublin, CA 94568

Phone: (800) 295-6402

Fax: (925) 833-7301

CHECK ANY THAT APPLY:

☐ NEW MEMBER

OR

CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ MEDICAL PLAN ☐ ADDRESS ☐ DEPENDENTS ☐ BENEFICIARY

INSTRUCTIONS: (Please read carefully before completing this form)

The Enrollment Form must be completed in order to enroll you and your dependents for Health & Welfare coverage under one of the Fund's Medical Plans, or to change your election of Medical Plan, to add a dependent, change your address, or to change your insurance beneficiary (SEE REVERSE). If you submit this Form, be sure to provide all of the information requested.

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

PARTICIPANT DATA					
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER - -		
MAILING ADDRESS			SEX (M/F)	DATE OF BIRTH / /	
CITY	STATE	ZIP	CELL PHONE ()	RECEIVE TEXT MSG?*	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)		DATE OF MARRIAGE / /	HOME PHONE ()	LOCAL UNION	
EMAIL ADDRESS		EMPLOYER	EMPLOYER ADDRESS		
* Mark "NO" if you do <u>NOT</u> want to receive important benefit notifications via text message					
FAMILY DATA					
FULL NAME	RELATIONSHIP**	SEX M/F	DATE OF BIRTH MONTH / DAY / YEAR	SOCIAL SECURITY #	
SPOUSE					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					
**Relationship – Wife/Husband, Domestic Partner, Son, Daughter, Stepson, Stepdaughter, Legal Guardianship. For coverage, you must provide a marriage certificate or certificate of domestic partnership for a spouse and birth certificate, adoption paperwork or legal guardianship paperwork for any dependents listed above.					
CHOICE OF PLANS					
MEDICAL SELECTION – CHOOSE ONE: ☐ KAISER KAISER MEDICAL NUMBER (IF ANY) _____ ☐ BLUE SHIELD HMO (MUST HAVE ENROLLED IN THE PLAN PRIOR TO JANUARY 1, 2012 AND BE A NON-RESIDENTIAL SPECIALIST)			Notes: <u>MEDICAL</u> ALL PARTICIPANTS <u>MUST</u> MAKE AN ELECTION <u>DENTAL & VISION</u> DENTAL & VISION COVERAGE IS PROVIDED THRU DELTA DENTAL & VSP TO ALL ELIGIBLE ACTIVE PARTICIPANTS AND THEIR DEPENDENTS.		
IF YOU ELECT KAISER, YOU MUST SIGN THE KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT ON THE REVERSE SIDE					

OVER

Kaiser Foundation Health Plan, Inc., 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 all Kaiser Permanente Plans

Date

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

For Administrator use only:

Effective Date:	Group Name:	Group ID:
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DEATH BENEFIT BENEFICIARY

You may designate any person or persons you want to be your beneficiary(ies) for the *Death and Accidental Death & Dismemberment Benefits* under the Plan. If you do not designate a beneficiary, your benefits will be paid to beneficiary(s) as provided for under the Plan. Please be sure to provide complete information, such as Jr., Sr., and middle names and initials, to avoid confusion. Please note that this designation applies only to death benefits under the U.A. Local 159 Health and Welfare Trust only.

BENEFICIARY OF DEATH BENEFIT

Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #	%
Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #	%

EMERGENCY CONTACT

Emergency Contact Name	Relationship	Home Phone	Cell Phone
		()	()
		()	()
		()	()

IMPORTANT NOTICE: I understand that the **benefits that I elect must remain in force for the entire Plan Year** and that I may not make a change in my benefits coverage during the Plan Year unless there is a Special Enrollment Event as defined by the Plan. I understand that it is my responsibility to **report to the Administrative office any change in the eligibility of my dependents or change in address/contact information as soon as possible** preferably within 31 days. I certify that **the information I have provided on this form is true and accurate.**

DATE _____

SIGNATURE _____

COMPLETE AND RETURN FORM TO LOCAL 159'S OFFICE – 1308 ROMAN WAY, MARTINEZ, CA 94553