Southern California United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC
6425 Katella Avenue, Cypress, CA 90630-5238
P.O. Box 6010, Cypress, CA 90630-0010
877-284-2320 • scufcwfunds.com

Enrollment Form Retirees

1. RETIREE ENROLLMENT/NOTICE OF CHANGE

Reason you are completing this form; check all boxes that apply. Plan changes, if approved, will be effective the first of the month following receipt of this form or if Open Enrollment (O.E.), on the O.E. effective date. Please print legibly using black ink.

☐ New Enrollment ☐ Add or Dis-enroll Dependent ☐ Name Change ☐ Medical Plan Change ☐ Plan Change - Once in 5 Years
☐ Open Enrollment ☐ Address Change ☐ Medicare Entitlement ☐ Dental Plan Change ☐ Dis-enrollment
☐ Enrollment following loss of other medical coverage (Proof of Loss of Coverage required.)

2. RETIREE'S INFORMATION

Last Name	First	Mid. Initial	Fund ID	Social Security #
fett				

Permanent Residence Address Street:	City	State	ZIP Code	Date of Birth (mm/dd/yyyy)
Mailing Address Street:	City	State	ZIP Code	☐ Male ☐ Female

Home phone / Cell phone	Totally Disabled? ☐ Yes ☐ No	Date of Disability (mm/dd/yyyy)	☐ Never Married ☐ Married____ (Date of Marriage (mm/dd/yyyy)) ☐ Divorced____ (Date of Divorce (mm/dd/yyyy)) ☐ Domestic Partner ☐ Widowed ☐ Separated
Retiree's Email Address	Emergency contact name	Emergency contact phone	

Are you eligible for Medicare? (See Section 2 Instructions) ☐ Yes ☐ No	Are you enrolled in Medicare Part A? ☐ Yes ☐ No	Are you enrolled in Medicare Part B? ☐ Yes ☐ No	Are you covered under another health plan? ☐ Yes ☐ No

Are you enrolled in MediCal or as an individual in a Medicare HMO? ☐ Yes Name of Plan ☐ No	Are you employed in a job in which you are eligible under this Fund or another employer's plan? ☐ Yes ☐ No	Name of Plan

Medical Plan Enrollment- Select one plan. Please refer to section 2 of the Form Instructions for additional information.

For Persons Not Eligible for Medicare:	*For Persons Eligible for Medicare:*
☐ **Indemnity PPO Medical Plan** - anthem.com/CA	☐ **Indemnity PPO Medical Plan**
☐ **Kaiser Permanente HMO Plan - kp.org PID# 101500 EU#**	☐ **Kaiser Senior Advantage** with Part D kp.org/medicare PID# 101500 EU#
Anthem Blue Cross HMO - anthem.com/CA #282241 Mark only ONE box:	☐ **Anthem Medicare Preferred PPO Group# CAEGR014**
☐ Select HMO Network - Find a PCP: tinyurl.com/SelectHMOSearch	
☐ Blue Cross HMO (CACare) Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch	
☐ Blue Cross HMO (CACare) Limited Choice Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch	

If Anthem HMO is selected, complete the selection below. You must choose one network for all non-Medicare family members for the entire year and each of you must choose a PCP/Medical Group in that network. You must reside in the chosen network's service area. You can review the service area ZIP Codes by visiting the HMO's website prior to making your selection.

PCP/Medical Group #/Enrollment #	Current patient? ☐ Yes ☐ No	Physician's Last Name	First

3. SPOUSE/DOMESTIC PARTNER'S INFORMATION

Spouse/Domestic Partner's Last Name	First	M.I.	Social Security #

Permanent Residence Address Street:	City	State	ZIP Code	Date of Birth (mm/dd/yyyy)
Mailing Address Street:	City	State	ZIP Code	☐ Male ☐ Female

Home phone / Cell phone	Totally Disabled? ☐ Yes ☐ No	Date of Disability (mm/dd/yyyy)	☐ Never Married ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed ☐ Separated

Are you eligible for Medicare? (See Section 2 Instructions) ☐ Yes ☐ No	Are you enrolled in Medicare Part A? ☐ Yes ☐ No	Are you enrolled in Medicare Part B? ☐ Yes ☐ No	Are you covered under another health plan? ☐ Yes ☐ No

Are you enrolled in MediCal or as an individual in a Medicare HMO? ☐ Yes Name of Plan ☐ No	Are you employed in a job in which you are eligible under this Fund or another employer's plan? ☐ Yes ☐ No	Name of Plan

Medical Plan Enrollment- Select one plan. Please refer to section 2 of the Form Instructions for additional information.

For Persons Not Eligible for Medicare:	*For Persons Eligible for Medicare:*
☐ **Indemnity PPO Medical Plan** - anthem.com/CA	☐ **Indemnity PPO Medical Plan**
☐ **Kaiser Permanente HMO Plan - kp.org PID# 101500 EU#**	☐ **Kaiser Senior Advantage** with Part D kp.org/medicare PID# 101500 EU#
Anthem Blue Cross HMO - anthem.com/CA #282241 Mark only ONE box:	☐ **Anthem Medicare Preferred PPO Group# CAEGR014**
☐ Select HMO Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch	
☐ Blue Cross HMO (CACare) Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch	
☐ Blue Cross HMO (CACare) Limited Choice Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch	

If Anthem HMO is selected, complete the selection below. You must choose one network for all non-Medicare family members for the entire year and each of you must choose a PCP/Medical Group in that network. You must reside in the chosen network's service area. You can review the service area ZIP Codes by visiting the HMO's website prior to making your selection.

PCP/Medical Group #/Enrollment #	Current patient? ☐ Yes ☐ No	Physician's Last Name	First

IMPORTANT - Signature(s) required at the end of this form.

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4. DENTAL PLAN SELECTION

Select one plan. Refer to the Summary Comparison of Medical and Dental Plans for cost of coverage and enrollment requirements.

☐ **Indemnity Dental Plan:** The Indemnity Dental Plan allows you to choose your own dentist.

OR

Prepaid Dental Plan: If you choose an office listed below, you must use services from that dental office. If you enroll you must use services from the dental office you choose below. If you enroll in the Prepaid Plan outside of Open Enrollment (OE), you must remain in that plan until the third OE following that change.

To dis-enroll, check here. ☐

☐ **Dr. Schnierow & Associates (Hawthorne)** 310-679-0106

☐ **San Diego Dental Group (La Mesa)** 619-464-4242

☐ **Santa Monica Dental Practice (Santa Monica)** 310-393-0743

☐ **Allcare Dental (Santa Ana)** 855-866-2273

☐ **Ilya Zak, DDS (Long Beach)** 562-426-6458

5. DEPENDENT CHILDREN INFORMATION

See Section 5 Instructions for request proof of dependent status..

5A. Last Name	First	Mid. Initial	Social Security #	
Address *(if different from Retiree)* Street:	City State	ZIP Code	☐ Male ☐ Female	Date of Birth

Do you claim this child on your federal income taxes? ☐ Yes ☐ No If you answered "No," answer the following questions:

Are you divorced from, separated from, or not living with the child's other parent? ☐ Yes ☐ No

Does the child's other parent claim the child as a dependent on his or her federal income taxes? ☐ Yes ☐ No

Is the child eligible for Medicare? ☐ Part A ☐ Part B Is the child totally & permanently disabled? ☐ Yes ☐ No

Anthem Blue Cross HMO #282241 Mark Only ONE Box ☐ **Anthem Medicare Preferred PPO Group# CAEGR014**

☐ Select HMO Network - Find a PCP, go to: tinyurl.com/SelectHMOSearch

☐ Blue Cross HMO (CACare) Network - Find a PCP go to: tinyurl.com/BlueCrossHMOSearch

☐ Blue Cross HMO (CACare) Limited Choice Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch

If Anthem HMO is selected, complete the selection below. You must choose one network for all non-Medicare family members for the entire year and each of you must choose a PCP/Medical Group in that network. You must reside in the chosen network's service area. You can review the service area ZIP Codes by visiting the HMO's website prior to making your selection.

PCP#	Current patient? ☐ Yes ☐ No	Physician's Last Name	First

5B. Last Name	First	Mid. Initial	Social Security #	
Address *(if different from Retiree)* Street:	City State	ZIP Code	☐ Male ☐ Female	Date of Birth

Do you claim this child on your federal income taxes? ☐ Yes ☐ No If you answered "No," answer the following questions:

Are you divorced from, separated from, or not living with the child's other parent? ☐ Yes ☐ No

Does the child's other parent claim the child as a dependent on his or her federal income taxes? ☐ Yes ☐ No

Is the child eligible for Medicare? ☐ Part A ☐ Part B Is the child totally & permanently disabled? ☐ Yes ☐ No

Anthem Blue Cross HMO #282241 Mark Only ONE Box ☐ **Anthem Medicare Preferred PPO Group# CAEGR014**

☐ Select HMO Network - Find a PCP, go to: tinyurl.com/SelectHMOSearch

☐ Blue Cross HMO (CACare) Network - Find a PCP go to: tinyurl.com/BlueCrossHMOSearch

☐ Blue Cross HMO (CACare) Limited Choice Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch

If Anthem HMO is selected, complete the selection below. You must choose one network for all non-Medicare family members for the entire year and each of you must choose a PCP/Medical Group in that network. You must reside in the chosen network's service area. You can review the service area ZIP Codes by visiting the HMO's website prior to making your selection.

PCP#	Current patient? ☐ Yes ☐ No	Physician's Last Name	First

5C. Last Name	First	Mid. Initial	Social Security #	
Address *(if different from Retiree)* Street:	City State	ZIP Code	☐ Male ☐ Female	Date of Birth

Do you claim this child on your federal income taxes? ☐ Yes ☐ No If you answered "No," answer the following questions:

Are you divorced from, separated from, or not living with the child's other parent? ☐ Yes ☐ No

Does the child's other parent claim the child as a dependent on his or her federal income taxes? ☐ Yes ☐ No

Is the child eligible for Medicare? ☐ Part A ☐ Part B Is the child totally & permanently disabled? ☐ Yes ☐ No

Anthem Blue Cross HMO #282241 Mark Only ONE Box ☐ **Anthem Medicare Prefered PPO Group# CAEGR014**

☐ Select HMO Network - Find a PCP, go to: tinyurl.com/SelectHMOSearch

☐ Blue Cross HMO (CACare) Network - Find a PCP go to: tinyurl.com/BlueCrossHMOSearch

☐ Blue Cross HMO (CACare) Limited Choice Network - Find a PCP: tinyurl.com/BlueCrossHMOSearch

If Anthem HMO is selected, complete the selection below. You must choose one network for all non-Medicare family members for the entire year and each of you must choose a PCP/Medical Group in that network. You must reside in the chosen network's service area. You can review the service area ZIP Codes by visiting the HMO's website prior to making your selection.

PCP#	Current patient? ☐ Yes ☐ No	Physician's Last Name	First

6. DIS-ENROLL

See Section 6 instructions.

Last Name	First	Social Security #	Date of Birth	Reason
Last Name	First	Social Security #	Date of Birth	Reason
Last Name	First	Social Security #	Date of Birth	Reason
Last Name	First	Social Security #	Date of Birth	Reason

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IMPORTANT - YOUR ENROLLMENT FORM CANNOT BE PROCESSED WITHOUT THE NECESSARY SIGNATURE(S).

- If you are enrolling/enrolled in the Indemnity PPO Medical Plan, sign only on signature line 1 below.
- If you are enrolling/enrolled in Kaiser, sign on both lines 1 and 2 below.
- If you are enrolling/enrolled in Anthem Blue Cross HMO/Medicare PPO, sign on both lines 1 and 3 below.

Hereby request the enrollment actions indicated and certify that all information and documentation provided is true, correct and complete. I hereby enroll myself and the eligible members of my family in the Medical and/or Dental Plan marked above. To the extent consistent with applicable law, I hereby authorize any medical or dental provider or other health care practitioner, hospital or other institution to furnish the United Food & Commercial Workers Unions and Food Employers Benefit Fund ("the Fund") any information required to process any claim for me or any dependent I enroll in these Plans. I also authorize the Fund, its agents, designees or representatives to disclose to any medical or dental provider or HMO or Prepaid Dental Plan, any medical or dental information required to process any claim. I understand that any dispute or controversy which may arise under the agreement between me (and/or any family member enrolled hereunder) and any HMO or Prepaid Dental Plan office must be submitted to binding arbitration in lieu of a jury or court trial. If I am not enrolled in a Medicare HMO, I hereby agree to maintain the Medical and /or Dental Plan coverage I have selected for 12 months from the effective date of coverage or until Open Enrollment. I recognize that I must pay a premium contribution to the Fund each month in order to maintain my coverage, and that the Fund may recover any unpaid premium from any Health and Welfare Benefits otherwise payable to me, terminate my participation in the Medical and/or Dental Plan and take other appropriate action permitted by law, if I do not make the required monthly contributions. I hereby request the enrollment choices as indicated on this form and certify that all information I have provided is true, correct and complete.

1. Signature of Participant _____ Date _____

Kaiser Permanente members - The Kaiser Foundation Health Plan 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 me, 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*.

2. If you are enrolling in the Kaiser Permanente HMO Plan, you MUST also sign here _____ 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.

Anthem Blue Cross™ Members

Requirement for Binding Arbitration

If you are applying for coverage, please note that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company require binding arbitration to settle all disputes, including but not limited to disputes relating to the delivery of service under the plan/policy or any other issues related to the plan/policy and claims of medical malpractice, if the amount in dispute exceeds the jurisdictional limit of small claims court and the dispute can be submitted to binding arbitration under applicable federal and state law, including but not limited to, the Patient Protection and Affordable Care Act. It is understood that any dispute, including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, regarding whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by applicable federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. This means that you and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company are waiving the right to a jury trial and participation in a class action for medical malpractice claims and any other disputes, including disputes, relating to the delivery of service under the plan/policy or any other issues related to the plan/policy.

3. If you are enrolling in an Anthem Blue Cross HMO/ Medicare PPO, you MUST also sign here _____ Date _____ Participant's Name (please print) _____