English

Local Union 831

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T 626.279.3080 • 1.877.572.7005 • F 626.279.3055

Participant's Agreement

Enrollment/Change Form Instructions

1 Member's Personal Information

- Member must complete information requested. If selecting Kaiser Permanente please make sure to sign the Kaiser Permanente Arbitration Agreement on this form or your form will be returned.

2 Dependent Information

- List family members to be covered. If additional lines are needed, you may complete an additional Enrollment/ Change Form.
- Provide proof of relationship.
  - Newborn dependents must be enrolled within 30 days.
  - Original Certificate of Marriage of your spouse and original Certificate of Birth of each dependent will be required to establish eligibility. Photocopies will not be accepted.
  - Effective January 1, 2011, dependent children up to twenty-six (26) years of age will be eligible for continued coverage.

3 Coordination of Benefits

- If you or any of your dependents are receiving other coverage, please provide information requested.
- Provide new Medicare requirement information. Failure to provide this information may delay eligibility.
- Provide your Health Insurance Claim Number (HICN) if you are receiving Medicare Part A or B or have received a Kidney Transplant or are on Dialysis.

4 Medical Plan Coverage Election

- Member must elect one medical plan.
  - If no medical plan is elected, member and all dependents enrolled on your Enrollment/Change Form will be enrolled into the Local 831 Indemnity PPO Plan.
  - If no plan level is elected, your coverage will be defaulted to Level 4.

5 Member's Signature

(Please read carefully before signing)

- Member must complete form, sign and date the Enrollment/Change Form.
- On behalf of myself and my eligible Dependents, I hereby apply for Health and Welfare care for medical, dental and vision services coverage offered through the Southern California Local 831 Employer Health Fund (the Welfare Plan), I understand, agree with as well as agree to comply with the terms and conditions below.
- Review your available plans and options.
- Select the benefit plan options most appropriate to you or your dependents.
- Submit supporting, original documentation, such as the original Certificates of Marriage and Birth to the Trust Fund Office if enrolling dependents for the first time. (Without the supporting, original documentation, your Enrollment/ Change Form may not be processed.)
  - I agree to promptly furnish such proof to the Board of Trustees and further agree to the preconditions for payment of any benefits for me or on behalf of my dependents.
  - Provide social security numbers for all of your dependents in order for them to be eligible for benefits, as required by federal law.
  - Provide additional information about any other group health plan coverage in Section 3, as required by federal law.

Continues on next page

Completion of your Enrollment/Change Form means that you are stating all information provided in Sections 1 through 5 are true, correct and current; and that you have read and agree with, as well as agree to comply with the following terms and conditions:

- I authorize the Welfare Plan or its representatives or designees to access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or health care operations of the Agreement or Policy.
- I authorize the Welfare Plan or its representatives, agent or designees to disclose to a hospital or health care service plan or insurer any such information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable the Welfare Plan to process claims.

Signature Required _____ Date _____

Plans Arbitration Agreements

Electing Kaiser Permanente (HMO Plan – Group 101135)

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 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 Kaiser Permanente Plan _____ Date _____

Electing 831 Indemnity (PPO Plan - Group 170058M001)

831 Indemnity Self-Funded Plan Arbitration Agreement: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

I agree to promptly reimburse the Trust Fund in full for any monies paid if the Trust Fund pays benefits for or on behalf of me or of any person listed as a dependent on my Enrollment/Change Form when I am or such person is not, in fact, eligible to the benefits or if the Trust Fund otherwise mistakenly pays benefits. I also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from my future benefits. I agree to pay all attorney fees and any cost of the Trust Fund, whether or not such an action proceeds to judgment if the Trust Fund files any legal action against me to recover any such monies, whether or not such an action proceeds to judgment. The Trustees reserve the right to change, add or eliminate benefits at any time.

Signature Required for Indemnity PPO Plan _____ Date _____

If you enroll in Kaiser, please make sure you sign the Kaiser Foundation Health Plan Arbitration Agreement.

Mail your Enrollment/Change Form to the Trust Fund Office.

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Q P / Q P 2 G E

ACTIVE/RETIREES

Enrollment/Change Form

ACTION (Check all that apply)
*Include Supporting Documents

ENROLLMENT REASON: New Hire Open Enrollment Other _____

*NEW ENROLLMENT Date of Hire _____

CHANGE - ADDRESS BENEFICIARY *ADD DEPENDENT

Effective Date of Coverage _____

*DELETE DEPENDENT Due to Death *MARITAL STATUS PLAN

Event Date (mm/dd/yyyy) _____ (date of qualified event such as loss of coverage, marriage, divorce, etc.)

SECTION 1 – MEMBER INFORMATION ☐ ACTIVE ☐ RETIREE

Member's Last Name	First Name	Middle Initial

Social Security Number	Gender	Birth Date (mm/dd/yyyy)	Preferred Language
	Male Female		English Spanish Other _____

Street Address	City	State	Zip Code

Home Phone	Cell Phone Text? Yes No	E-mail Address

Marital Status	Retirement Date (mm/dd/yyyy)	Level Option
Married Single Divorced Separated Widowed		1 2 3 4

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:
Receiving Medicare? Yes No Part A Effective Date _____ (Submit a copy of your Medicare card) Part B Effective Date _____	Kidney Transplant? Yes No Date of Transplant _____
Health Insurance Claim Number (HICN) _____	Dialysis? Yes No Date of Dialysis _____

SECTION 2 – DEPENDENT INFORMATION - List spouse and eligible dependents who will be covered under the Plan

If you have more than 4 dependents, please complete an additional Enrollment Form

1

Spouse's Last Name	First Name	Middle Initial	Social Security Number

Birth Date (mm/dd/yyyy)	Gender	Marriage Date (mm/dd/yyyy)	Domestic Partner Role
	Male Female		Spouse Domestic Partner

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? Yes No Part A Effective Date _____ (Submit a copy of your Medicare card) Part B Effective Date _____	Kidney Transplant? Yes No Date of Transplant _____	
Health Insurance Claim Number (HICN) _____	Dialysis? Yes No Date of Dialysis _____	

2

Dependent's Last Name	First Name	Middle Initial	Social Security Number

Birth Date (mm/dd/yyyy)	Gender	
	Male Female	Newborn Child Adoption/Legal Custody Child Date _____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? Yes No Part A Effective date _____ (Submit a copy of your Medicare card) Part B Effective date _____	Kidney Transplant? Yes No Date of Transplant _____	
Health Insurance Claim Number (HICN) _____	Dialysis Yes No Date of Dialysis _____	

SECTION 2 – DEPENDENT INFORMATION (continued)

3

Dependent's Last Name	First Name	Middle Initial	Social Security Number

Birth Date (mm/dd/yyyy)	Gender	Newborn Child / Adoption/Legal Custody Child
	Male Female	Date_____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective date _____ (Submit a copy of your Medicare card) Part B ☐ Effective date _____	Kidney Transplant? Yes No Date of Transplant _____	
Health Insurance Claim Number (HICN) _____	Dialysis? Yes No Date of Dialysis _____	

4

Dependent's Last Name	First Name	Middle Initial	Social Security Number

Birth Date (mm/dd/yyyy)	Gender	Newborn Child / Adoption/Legal Custody Child
	Male Female	Date_____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? Yes No Part A Effective date _____ (Submit a copy of your Medicare card) Part B Effective date _____	Kidney Transplant? Yes No Date of Transplant _____	
Health Insurance Claim Number (HICN) _____	Dialysis? Yes No Date of Dialysis _____	

SECTION 3 – COORDINATION OF BENEFITS

If you or your spouse, or any dependents are covered by Medicare or any other Group insurance policy providing medical benefits, please complete this section.

Where are your claims sent?	Company Name	Company Address (City, State, Zip Code)	Telephone
Policy Holder Information	Name of Policy Holder	Employer	Policy Effective Date (mm/dd/yyyy)
	Family Member(s) Covered (1) (2) (3) (4)		
Reason for Medicare	Health Insurance Claim Number (HICN) _____ End Stage Renal Disease Disabled Over 65		Medicare Effective Date (mm/dd/yyyy)

SECTION 4 – MEDICAL PLAN COVERAGE SECTION - In case of a discrepancy between the Participant Agreement, charts and other information contained in this Enrollment/Change Form, the language to your elected plan will take precedence.

Elect one Medical Plan. New participants who do no select a Medical Plan will be defaulted into the Indemnity PPO Plan.

✓ (Elect) One Medical Plan Below	Medical Plan Options	Benefits Administered by	Comments	Binding Arbitration Required
	Kaiser Permanente (HMO)	Kaiser Foundation Health Plan	Provide your Kaiser Permanente Medical Record Number _____ Kaiser Permanente Purchaser I.D. Number 101135 Enrollment Unit _____	Yes
	Indemnity PPO Medical Plan	Local 831 H&W Plan Trust Fund	Southern California Local 831 Employer Health Fund PPO Plan uses the Anthem Blue Cross Prudent Buyer Plan, a PPO network.	Yes

SECTION 5 – MEMBER'S SIGNATURE - Your signature below confirms that you have read and understand and agree to the terms and conditions of the Participant Agreement attached.

Member's Signature X _____ **Date**_____