



B.A.C. Trust Funds

B.A.C. Local No. 3 Pension Plan
B.A.C. Local No. 3 Defined Contribution Pension Plan
B.A.C. Local No. 3 Health & Welfare Trust Fund
B.A.C. Local No. 3 Vacation Trust Fund

ENROLLMENT FORM

Date of Hire: _____
Event Date: _____
Effective Date: _____

CHECK ALL THAT APPLY: ☐ New Enrollment ☐ Adding Dependents ☐ Plan Change ☐ Address Change

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ GENDER: Male _____ Female _____

EMAIL: _____ PHONE NUMBER: (____) _____

MEDICAL PLAN (CHOOSE ONE):

☐ BLUE CROSS (INDEMNITY PLAN)

☐ KAISER PERMANENTE (Group# 7748-0000)

***If enrolling in Kaiser, you must also sign the Kaiser Arbitration Agreement (below).**

DENTAL PLAN (CHOOSE ONE):

☐ DELTA DENTAL PPO

☐ DELTA CARE -DHMO

Medicare Claim Number: **(including the letter(s) that follows the number)**

(Applicable only when a member, a spouse, or a covered dependent is age 65 or older; or is on Medicare disability.)

Member # _____ Spouse # _____ Dependent # _____
and Name _____

DEPENDENTS - (Including Spouse)

(ATTACH LEGAL DOCUMENTATION THAT APPLIES: birth certificate(s), marriage certificate, adoption papers, guardianship papers)

FULL LEGAL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	RELATIONSHIP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 the Kaiser Permanente Plan

Date

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE _____ DATE: _____

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