# HEAT & FROST INSULATORS AND ASBESTOS WORKERS HEALTH AND WELFARE TRUST FUND

## PARTICIPANT ENROLLMENT FORM

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:_____ LOCAL: _____

EMAIL:_____ PHONE NUMBER: (____)_____ GENDER: Male____ Female ____

**MAINTENANCE, SHIPYARD, AND PRE-APPRENTICE:**

**LOCAL 5:**

☐ MEDICAL: (Provided By) Kaiser Foundation Health Plan

☐ DENTAL: Delta Dental (HMO)

**LOCAL 135:**

☐ MEDICAL: Anthem Blue Cross

☐ DENTAL: First Dental Health *(Fee for Service Plan)*

**JOURNEYMAN, APPRENTICE, AND FIRE/SAFETY TECHNICIAN:**

**LOCAL 5:**

MEDICAL: CHOOSE ONE

☐ Anthem Blue Cross (PPO Plan)

☐ Kaiser Foundation Health Plan

DENTAL: CHOOSE ONE

☐ First Dental Health *(Fee for Service Plan)*

☐ Delta Dental (HMO)

**LOCAL 135:**

MEDICAL: CHOOSE ONE

☐ Anthem Blue Cross (PPO Plan)

☐ United Healthcare (HMO Plan)

DENTAL: CHOOSE ONE

☐ First Dental Health *(Fee for Service Plan)*

☐ United Healthcare Dental

**DEPENDENTS - (Including Spouse)**

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

| FULL NAME | RELATIONSHIP | DATE OF BIRTH | SSN | GENDER |
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**Kaiser Foundation Health Plan Arbitration Agreement – CALIFORNIA ONLY**

**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**

*It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.*

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 it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

**MEMBER'S SIGNATURE**_____ **DATE** _____