IBEW LOCAL 595 TRUST FUNDS

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: _____ GENDER: (Mark One) Male _____ Female _____

PHONE NUMBER: (_____) _____ EMAIL: _____

ACTIVE/NON-MEDICARE RETIREES MEDICAL PLAN
(CHOOSE ONE): *Actives subject to $350.00 Monthly Buy-up for non-Base Medical Plan.

☐ INDEMNITY PLAN with Blue Cross PPO, Dental & Vision *
☐ ADDITIONAL DEDUCTIBLE INDEMNITY PLAN with Blue Cross PPO without Dental or Vision **(Deductible is $3,554 for Individuals & $3,754 for the Family)**
☐ UNITED HEALTH CARE HMO *
☐ KAISER (Base Medical Plan)

DENTAL: (CHOOSE ONE) Not available with ADDITIONAL Deductible Indemnity Plan Option
☐ DELTA DENTAL
☐ UNITED HEALTH CARE DENTAL

MEDICARE RETIREE + DEPENDENTS
(CHOOSE ONE):
☐ UHC MEDICARE ADVANTAGE NATIONAL PPO (dependents) UNITED HEALTH HMO
☐ KAISER - SENIOR ADVANTAGE (dependents) KAISER

VISION:
Vision care for **Active/Non-Medicare Retirees** is provided through Vision Service Plan (VSP)

Vision Care for **Medicare Retirees** is provided through the Carrier.

Medicare Claim Number including the letter(s) that follows the number
(Only applies when member, spouse, or a covered dependent is age 65 or older or on Medicare disability – Please include copy of card)

Member #: _____ Spouse #: _____ Dependent Name/#: _____

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

-OVER-

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www.ibew595benefits.org • staff@ibew595benefits.org

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.*

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:** _____