OPERATING ENGINEERS LOCAL 501 SECURITY FUND

ENROLLMENT FORM

ENROLLMENT/CHANGE REASON: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ SEX: _____MALE _____ FEMALE

EMPLOYER_____ DATE OF HIRE: _____ LOCAL UNION #_____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL:**
☐ BLUE CROSS (PPO)	☐ DELTA DENTAL (PPO)
☐ KAISER PERMANENTE (HMO) (Group# 229194)	☐ DELTA CARE (DHMO)
	VISION:
	COVERED BY VISION SERVICE PLAN (VSP)

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

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	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:** _____

Mailing Address: P.O. Box 990 ◆ West Covina, CA 91793
Physical Address: 1050 Lakes Drive Suite 120 ◆ West Covina, CA 91790
8311 West Sunset Road Suite 250 ◆ Las Vegas, NV 89113
Phone 626·646·1079 ◆ Toll Free 800·320·0106 ◆ Facsimile 626·931-1368
www.oelocal501benefits.org ◆ staff@oelocal501benefits.org

Coordination of Benefits

☐ **If you and/or your dependents DO NOT have any other insurance coverage, please check this box and sign/date at the bottom of the page under "Member Statement" (section E)**

Member Information: Name: _____ SSN or ID: _____

Other Insured Person (Policy Holder):

Name: _____ Date of Birth: _____ Relationship to Member: _____

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

OTHER HEALTH COVERAGE INFORMATION

A Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Medical Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

B Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Dental Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

C Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Vision Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

D Does this plan include **Prescription** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Prescription Carrier:_____Phone#:_____
Effective Date:_____ Policy/Group Number:_____

List all covered dependents:

1._____ Social Security#: _____-_____-_____
2._____ Social Security#: _____-_____-_____
3._____ Social Security#: _____-_____-_____
4._____ Social Security#: _____-_____-_____
5._____ Social Security#: _____-_____-_____

Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation, court order or marriage work related group coverage.

Is there a court order that determines responsibility for health care coverage or custody? □Yes or □ No

If yes, attach a copy of the sections that apply to health care responsibility and/or custody arrangements

Name of person responsible for child's heath care coverage?		Employer	Birthdate
Insurance company name	Insurance company city	State	Phone number
Enrollee ID/policy number	Group number	Effective date	Cancellation date (if applicable)

Custody Insurance:

1. Are you divorced or separated from the parent of any dependent on this policy listed above? □Yes or □ No
   - If Yes (continue) If No (skip to section E) ***(Indicate which child by marking appropriate circle)***
2. Does one parent/guardian have full custody of the child(ren)? □Yes or □ No (If yes, which child)? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
   - Parent: _____ Date: _____
3. Is one parent required by court decree to provide health insurance for the children? □Yes or □ No ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
   - Parent: _____ Date: _____

****If court decree is present, please provide an ATTACHMENT to the back of this copy****

Medicare/Medicaid (if applicable)	Are you or anyone else on your policy covered by Medicare or Medicaid? □Yes or □ No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? □Yes or □ No		Is the Medicare coverage because of? □Age or □ Disability	

****** Medicare coverage includes: (check all that apply, followed by effective date) ******

Type: A □ B □ C □ D □ Effective date: A)_____ B)_____ C)_____ D)_____

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

E	**Signature**		Telephone Number:	Date: