

# PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

Date of Hire: \_\_\_\_\_  
Event Date: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

## ENROLLMENT FORM

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

EMPLOYEE'S FULL NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ GENDER: (Mark One) Male \_\_\_\_\_ Female \_\_\_\_\_

<u>MEDICAL PLAN: OREGON (Provided By):</u>	<u>DENTAL (CHOOSE ONE):</u>	<u>VISION (Provided By):</u>
<input type="checkbox"/> KAISER PERMANENTE HMO PLAN (Group # 1672)	<input type="checkbox"/> STANDARD DENTAL (PPO)	VISION SERVICE PLAN (VSP)
<b>**If enrolling in Kaiser you must also sign the Kaiser Arbitration Agreement below**</b>		<b>**Complete enclosed Dental Plan Enrollment Form or Declination of Coverage Form. **</b>

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	SSN	GENDER

#### 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

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:

## 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**

<b>A</b>	Does this plan include <u>Medical</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO
	Name of Medical Carrier: _____ Phone#: _____
	Effective Date: _____ Policy/Group Number: _____
<b>B</b>	Does this plan include <u>Dental</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO
	Name of Dental Carrier: _____ Phone#: _____
	Effective Date: _____ Policy/Group Number: _____
<b>C</b>	Does this plan include <u>Vision</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO
	Name of Vision Carrier: _____ Phone#: _____
	Effective Date: _____ Policy/Group Number: _____
<b>D</b>	Does this plan include <u>Prescription</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> 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 health 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? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? <input type="checkbox"/> Yes or <input type="checkbox"/> No		Is the Medicare coverage because of? <input type="checkbox"/> Age or <input type="checkbox"/> 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.

<b>E</b>	Signature	Telephone Number:	Date:
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