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 _____

MEDICAL PLAN: CALIFORNIA (CHOOSE ONE):	**DENTAL (CHOOSE ONE):**	**VISION (Provided By):**
☐ KAISER PERMANENTE HMO PLAN (**Active** Grp# 8012-0)	☐ SUN LIFE DENTAL	VISION SERVICE PLAN (VSP)
☐ KAISER PERMANENTE HMO PLAN (**Retiree** Grp# 8012-1)	☐ DENTAL HEALTH SERVICES	
****If enrolling in Kaiser you must also sign the Kaiser Arbitration Agreement below****	☐ STANDARD DENTAL (PPO)	
	****Complete enclosed Dental Plan Enrollment Form or Declination of Coverage Form. ****	

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

DEPENDENTS - (Including Spouse)

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

FULL 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 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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