Sacramento Independent Hotel, Restaurant and Tavern Employees Trust Funds

ENROLLMENT FORM

Event Date: _____
Effective Date: _____

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:**
☐ INDEMNITY PLAN A (PPO)	COVERED BY INDEMNITY DENTAL PLAN (PPO)
☐ INDEMNITY PLAN B (PPO)	**VISION:**
☐ KAISER PERMANENTE (HMO) (Group# 37100)	COVERED BY VISION SERVICE PLAN (VSP)
☐ WESTERN HEALTH ADVANTAGE (HMO)	

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 1306 • San Ramon, CA 94583
7180 Koll Center Parkway, Suite 200 • Pleasanton, CA 94566
Telephone (925) 398-7044 • Toll Free (877) 893-1500 • Fax (925) 462-0108
www.SIHRTEbenefits.org

OTHER INSURANCE INQUIRY

Please complete and return this form, if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

**** Please include a copy of the FRONT AND BACK of each card (Medical, Dental, Vision) ***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

General Information:

Member's Name_____ SSN or ID#: _____

Name of Other Insured Person (Policy Holder):_____

Other Policy Holder's Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Does this plan include **Medical** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Medical Carrier: _____ Phone #: _____

Address: _____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

Does this plan include **Dental** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Phone #: _____

Address: _____

Effective Date:_____ Termination Date (if applicable): _____ Policy/Group Number:_____

Does this plan include **Vision** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____Phone #: _____

Address: _____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

If other coverage is for a child, please circle one regarding you and the other parent:
Married Divorced Domestic Partner (boyfriend/girlfriend)

- **If divorced or separated from other parent, please include a full copy of your Dissolution of Marriage Judgment or other child custody documents.**

Coverage is (circle): Single Family Children are covered until age: _____

List **ALL** Covered Dependents including Spouse if applicable.

1._____ 3. _____
2._____ 4. _____

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.

_____ _____

Member/Dependent Signature **Date**