Northern California Sheet Metal Workers

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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: _____

PHONE NUMBER: (_____)_____ GENDER: (Circle One) Male Female

DATE OF HIRE:_____ EVENT DATE:_____ EFFECTIVE DATE:_____

CHOICE OF MEDICAL PLAN (CHOOSE ONE):	CHOICE OF DENTAL PLAN (CHOOSE ONE):
☐ INDEMNITY PLAN /BLUE SHIELD ☐ KAISER PERMANENTE DEDUCTIBLE PLAN (Active Grp#98-00) ☐ KAISER PERMANENTE DEDUCTIBLE PLAN (Retiree Grp#98-01)	☐ DELTA DENTAL PPO ☐ BRIGHT NOW DENTAL

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, divorce 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, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any 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'S SIGNATURE _____ **DATE** _____

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 also list any medical coverage/insurance provided to a dependent child as a result of the child's employment or a child's spouses' employment.

IF THERE IS NO OTHER INSURANCE FOR YOUR DEPENDENTS, INITIAL HERE_____ AND SKIP TO THE MEMBER STATEMENT.

**** 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**