Administered by BeneSys

U.A. Local No. 393 Benefit Funds

HEALTH & WELFARE, SUB, DEFINED BENEFIT PENSION AND DEFINED CONTRIBUTION

6293 San Ignacio Ave ▪ San Jose, CA 95119 ▪ P.O. Box 2460 ▪ San Jose, CA 95109-2460
(408) 588-3751 ▪ (408) 436-8210 fax ▪ Staff@ualocal393benefits.org ▪ www.ualocal393benefits.org

ENROLLMENT FORM – COMMERCIAL

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

GENDER: ◯ Male ◯ Female

EMPLOYEE'S FULL NAME:_____ S.S.#:_____ DATE OF BIRTH:_____

ADDRESS:_____ CITY: _____ STATE:_____ ZIP:_____

PHONE NUMBER: (_____)_____ EMAIL: _____

CURRENT LOCAL UNION AFFILIATION: _____ EMPLOYMENT CLASSIFICATION: _____

CHOICE OF MEDICAL PLAN (CHOOSE ONE):	**DENTAL:** DELTA DENTAL
◯ INDEMNITY PLAN (PPO) - BLUE CROSS	**VISION:** VISION SERVICE PLAN (VSP)
◯ KAISER PERMANENTE (HMO) – CID#93	

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

NOTE: IF YOU ARE ADDING A DOMESTIC PARTNER - PLEASE CONTACT THE TRUST FUND OFFICE FOR INSTRUCTIONS AND ENROLLMENT PACKET

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION THAT APPLIES**: birth certificate(s), marriage certificate, adoption papers, guardianship papers, divorce papers and proof of support.)

FULL NAME	RELATIONSHIP	BIRTH DATE	SSN	GENDER

Kaiser Foundation Health Plan, Inc., 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 KaiserPermanente 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** _____