Health and Welfare Fund
Teamsters Local Union No. 856

Important Enrollment Information

Member Name:_____ **Social Security Number:** _____

INSTRUCTIONS: (Please read carefully before completing the "Enrollment Form")

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health & Welfare coverage under one of the Fund's Plans. Be sure to complete all of the information requested on the Enrollment Form. Under the terms of your coverage, you may make an election of the Medical and Dental Plan. Be sure to complete the box marked "CHOICE OF PLANS". Please read your Summary Plan Description for descriptions of the various plans. Remember, once you make the election, changes are only permitted once in a 12-month period.

TO ADD OR CHANGE YOUR DEPENDENT, THE FOLLOWING DOCUMENTATIONS MAY BE REQUIRED.

- Copies of certified marriage certificate or divorce papers.
- Copies of certified birth certificates for dependent children.
- Foster & Adopted children: Legal guardianship or court adoption papers.

DEPENDENT ELIGIBILITY AND ENROLLMENT - WHO IS ELIGIBLE:

If YOU qualify for benefits, the following dependents may be covered:

- Your spouse or domestic partner.
- Unmarried children who are less than 26 years of age. The definition of unmarried children are those declared by you as dependents for Federal Income Tax purposes and include your:
  - Natural Children
  - Stepchildren
  - Legally Adopted Children
  - Children placed for Adoption
  - Children for whom you have been legally appointed guardian
- Disabled dependent children over age 26 and incapable of self-supporting employment because of mental retardation or physical handicap will have eligibility extended.

Eligibility for all persons listed above shall be subject to all provisions and limitations of the Trust Agreement and Plan Document, as well as to any rules or regulations adopted by the Board of Trustees. If selecting either Kaiser or Anthem HMO you must sign and date in the appropriate arbitration language box.

KAISER PERMANENTE 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 of Participant (Required): Date:

PLEASE SEE REVERSE SIDE FOR ANTHEM BLUE CROSS (HMO) HEALTH PLAN ARBITRATION LANGUAGE

ANTHEM BLUE CROSS (HMO) HEALTH PLAN ARBITRATION LANGUAGE:

PLEASE READ CAREFULLY – SIGNATURE REQUIRED: I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE: You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

- The date eligibility for COBRA Continuation Coverage ends, or
- The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
- The date your employer discontinues coverage with Anthem Blue Cross, or
- The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
- The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information. The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay you initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W-9 Certification Language
I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION:
If you are applying for coverage, please note that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company require binding arbitration to settle **ALL** disputes including but not limited to disputes relating to the delivery of service under the Plan/Policy or any other issues related to the Plan/Policy and claims of medical malpractice, if the amount in dispute exceeds the jurisdictional limit of small claims court and the dispute can be submitted to binding arbitration under applicable federal and state law, including but not limited to, the patient protection and affordable care act. It is understood that any dispute including disputes relating to the delivery of services under the Plan/Policy or any other issues related to the Plan/Policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. This means that you and Anthem Blue Cross and/or Anthem Blue Cross life and health insurance company are waiving the right to a jury trial and participation in a class action for both medical malpractice claims, and any other disputes including disputes relating to the delivery of service under the Plan/Policy or any other disputes including disputes relating to the delivery of service under the Plan/Policy or any other issues related to the Plan/Policy.

Signature of Participant (Required): Date:

Health and Welfare Fund
Teamsters Local Union No. 856

City of Santa Rosa Enrollment Form

INSTRUCTIONS: Complete EACH section front and back. SIGN and DATE. Use INK. PRINT. Data provided will replace all information on file with the Trust Office. For questions, call ***1 (800) 297-4595***.

MAIL TO: Teamsters Local Union No. 856
Health & Welfare Fund
2323 Eastlake Avenue East
Seattle, WA 98102-3393

NOTE: Once enrolled you may register at www.nwadmin.com and make future changes to your participant data on-line in lieu of resubmitting this form.

ADMINISTRATIVE USE ONLY

GROUP NO: _____
EFF. DATE: _____
DATE: _____
INITIAL: _____

PLEASE CHECK ALL THAT APPLY:

☐ NEW HIRE
☐ OPEN ENROLLMENT

CHANGE OF:

☐ NAME ☐ ADDRESS ☐ PLAN ☐ MARITAL STATUS ☐ ADD/DELETE DEPENDENT(S)

PARTICIPANT DATA

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	CITY, STATE, ZIP	PHONE NUMBER (☐ Home ☐ Cell)

DATE OF BIRTH	GENDER ☐ M ☐ F	EMAIL ADDRESS	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED DATE:____/____/____

EMPLOYER (COMPANY NAME)	DATE OF HIRE	RE-HIRE DATE:_____ PART-TIME TO FULL-TIME EMPLOYMENT DATE:_____

PARTICIPANT ELIGIBLE DEPENDENT DATA

☐ Check here if you have no spouse, domestic partner, or eligible dependents

If Adding NEW Dependents please submit copies of Marriage Certificate for Dependent Spouse. Attach copies of Birth Certificates for dependent children up through age 25. For Domestic partners, the member must apply and qualify separately for Domestic partner eligibility through the Trust Fund Office. Attach copies along with this form.

RELATIONSHIP	LAST NAME/FIRST/INITIAL	DATE OF BIRTH	GENDER	SOCIAL SECURITY NO.	IRS QUALIFIED*	PRIMARY CARE PHYSICIAN (PCP) NO.**	CURRENT PCP	Receiving Medicare **Part A or B**	Kidney Transplant or Dialysis
SELF					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ SPOUSE ☐DOMESTIC PARTNER					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
					☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

*If children are 26 or over you must check the appropriate box.
**Applies to Anthem Blue Cross HMO member only – If no Primary Care Physician number listed, Anthem Blue Cross will automatically assign you and your family (if applicable) a primary care physician.

PLEASE COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF MEDICARE CARD IF YOU OR A DEPENDENT ARE ENROLLED IN MEDICARE

Name of Individual receiving Medicare:	Receiving Part A? □ Yes □ No If Yes, Effective Date: _____/____/_____
	Receiving Part B? □ Yes □ No If Yes, Effective Date: _____/____/_____

YOU MUST COMPLETE THIS SECTION BELOW IF YOU ANSWERED "YES" TO TRANSPLANT OR RECEIVING KIDNEY DIALYSIS

Name of Individual receiving Transplant or Dialysis:	Receiving Kidney Transplant? □ Yes □ No If Yes, Date of Transplant: _____/____/_____
	Receiving Dialysis? □ Yes □ No If Yes, Date of 1st Dialysis: _____/____/_____

PLEASE SELECT YOUR CHOICE OF MEDICAL PLAN

☐ **DIRECT PAY (BLUE CROSS PPO)**	☐ **KAISER PERMANENTE HMO w/RX (Signature Required on Separate Enrollment Information Form)**	☐ **ANTHEM BLUE CROSS HMO – w/RX (Signature Required on Separate Enrollment Information Form)**	☐ **OPT OUT OF MEDICAL COVERAGE**

IMPORTANT NOTICE: I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the Health Maintenance Organization (HMO) service agreement or preferred provider plan regulations, whichever applies. I understand the service agreement provides that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me, believed that some conduct in, or arising from my membership with the HMO, HMO hospitals, or the HMO medical group, as a member or as a patient, has caused any harm, must be submitted to binding arbitration instead of court trial.

SIGNATURE OF PARTICIPANT _____ **DATE** _____/_____/_____

IF YOU HAVE ADDITIONAL DEPENDENTS, DEPENDENTS ON MEDICARE OR DEPENDENTS RECEIVING TRANSPLANT OR DIALYSIS - PLEASE ATTACH A SEPARATE SHEET OF PAPER

FRONT - PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE BOTH SIDES OF FORM (SEE BACK TO COMPLETE).

Health and Welfare Fund
Teamsters Local Union No. 856

City of Santa Rosa
Enrollment Form – Side 2

DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another healthcare plan and the natural parents are divorced or separated, please complete the following:

NAME OF PARENT WITH CUSTODY (IF PARENTS HAVE JOINT CUSTODY, INDICATE HERE ☐)	BIRTH DATE OF OTHER PARENT

If divorced, did a court establish financial responsibility for the child(ren)'s health care?	☐ YES ☐ NO	If, yes, the responsible person(s) are:	
NAME	STREET ADDRESS OR PO BOX	CITY, STATE, ZIP	PHONE NUMBER

OTHER INSURANCE DATA

THIS FORM WILL BE RETURNED IF THIS SECTION IS NOT **COMPLETED IN FULL**, WHICH WILL DELAY THE ENROLLMENT PROCESS.

☐ Check here if you and your dependents have no other insurance.

If you or any of your dependents have or had coverage with any other healthcare plan in the last 12 months (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this Trust, please complete this section.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage (check all that apply)	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ Other
Name of Insured Person			
SSN of Insured Person			
Name(s) of Dependent(s) covered under this insurance			
Insured's Relationship to Dependent(s)			
Name of Insured Person's Employer			
Name of Insurance Company			
Street Address or PO Box			
City			
State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			
Termination Date of Coverage, if not Active			

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA OR SUBMIT THE REQUIRED DEPENDENT VERIFICATION DOCUMENTATION WITH THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS.

It is a crime to knowingly provide false, incomplete, or misleading information to the Trust Administrative Office for the purpose of defrauding the Trust. Penalties include imprisonment, repayment of all claims paid inappropriately, fines, and denial of insurance benefits. With my signature, I hereby certify that the information provided on this Enrollment Form is true and correct and I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to the Teamsters Local Union No. 856 Health & Welfare Fund or its designated agent.

SIGNATURE OF PARTICIPANT _____ **DATE** _____/_____/_____

BACK