

****PLEASE TYPE OR PRINT – RETURN TO ADMINISTRATIVE TRUST FUNDS OFFICE****

Last Name		First Name		M.I.	SOCIAL SECURITY NUMBER															
Street Address – Do NOT use P.O.Box										Apt. #		City			State	Zip Code		Phone Number ()		
Local # 11		Male <input type="checkbox"/> Female <input type="checkbox"/>		<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed		Date of Marriage						

I.

Options	<input type="checkbox"/> Normal Retirees	<input type="checkbox"/> Early Retirees	<input type="checkbox"/> Disability Retirees
Medical (Select <u>one</u> plan)	<input type="checkbox"/> Kaiser Permanente Senior Advantage (HMO) <input type="checkbox"/> UnitedHealthcare Secure Horizons (HMO) <input type="checkbox"/> Premium Reimbursement <input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Kaiser Permanente (HMO)- Group 101155-01 <input type="checkbox"/> UnitedHealthcare (HMO) – Group 144787 <input type="checkbox"/> Premium Reimbursement	<input type="checkbox"/> Kaiser Permanente (HMO) - Group 101155-01 <input type="checkbox"/> UnitedHealthcare (HMO) – Group 144787/144788/004257 <input type="checkbox"/> Premium Reimbursement <input type="checkbox"/> Medicare Supplement
DENTAL (Select <u>one</u> plan) Applicable only to Disability Retirees	N/A Contact your selected medical provider	N/A	<input type="checkbox"/> United Concordia (PPO) <input type="checkbox"/> Cigna (DHMO) <input type="checkbox"/> DeltaCare (DHMO) <input type="checkbox"/> MetLife/Safeguard (DHMO) <input type="checkbox"/> United Concordia (DHMO)

II. After selecting your plan, please complete information below.

FAMILY INFORMATION – Please list eligible family members to be enrolled.						This section must be completed if you have selected UnitedHealthcare															
	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	UnitedHealthcare Primary Care Physician Code										Is this your current MD?					
YOU				- -	/ /																<input type="checkbox"/> Y <input type="checkbox"/> N
SPOUSE				- -	/ /																<input type="checkbox"/> Y <input type="checkbox"/> N

If you or your spouse are totally disabled, or enrolled in Medicare A and/or B, please indicate.

Name _____ Totally Disabled Medicare A B

***** If you are enrolled in Medicare A and/or B, please include a copy of your Medicare card *****

If you or your spouse have other insurance, please complete:

Name of other insurance _____ Policy # _____ Insured Name _____

I understand this election will remain in effect so long as I remain eligible, or until I make another election during an open enrollment period. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plan elected. I understand that it is my responsibility to report any change in the eligibility of my dependents; that the benefits and services of the elected plan are coordinated with those provided by any other group hospital, medical benefit, dental plan or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any plan (Kaiser or UnitedHealthcare) member and any such plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

RETIREE SIGNATURE	DATE SIGNED
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FOR OFFICE USE ONLY

CURRENT ELIGIBILITY:	EFFECTIVE DATE:
COMMENTS:	