UNITEDHEALTHCARE SINGATUREVALUE HARMONY (HMO) "HARMONY HMO" ENROLLMENT FORM – ACTIVE AND EARLY RETIREES

Southern California IBEW-NECA Health Plan
6023 Garfield Avenue, City of Commerce, California 90040
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091
(323) 221-5861 or (800) 824-6935 (Nationwide) Fax No.: (323) 726-3520 website: www.scibew-neca.org

PART 1: GENERAL INFORMATION

❶ READ THE INSTRUCTIONS ON THIS FORM CAREFULLY. YOU NEED TO FILL OUT THIS FORM COMPLETELY.

❷ PLEASE PRINT IN BLACK OR BLUE INK OR TYPE CLEARLY.

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER
			___–___–____

STREET ADDRESS – **DO NOT USE P.O. BOX**	APT #:	CITY	STATE	ZIP CODE

DATE OF BIRTH	TELEPHONE NUMBER	GENDER
	( )	☐ MALE ☐ FEMALE

MARITAL STATUS

☐ SINGLE, NEVER MARRIED	☐ MARRIED or RE-MARRIED DATE OF MARRIAGE: _____ (INCLUDE A COPY OF YOUR CERTIFIED MARRIAGE CERTIFICATE WITH THIS FORM)
☐ DIVORCED/LEGALLY SEPARATED/ANNULMENT (INCLUDE A COPY OF YOUR JUDGMENT OF DISSOLUTION WITH THIS FORM)	

PART 2: PLAN SELECTIONS

ELECT ENROLLMENT IN THE HARMONY HMO(PARTICIPANT SIGNATURE REQUIRED)

☐ **I elect to enroll in the Harmony HMO _____ (Initials)**	I *elect* to enroll in the Harmony HMO effective January 1, 2020. I understand if I elect to change to the Harmony HMO, I will not be able to re-enroll in the Flex HMO (Traditional plan). I also understand that the Southern California IBEW-NECA Health Trust Fund Board of Trustees has a fiduciary responsibility to prudently manage the Plan. In order to meet this responsibility, the Trustees periodically review the cost and benefits of various Plans. The Board of Trustees may find it necessary to change, reduce or eliminate benefits.

MEDICAL PLAN SELECTION - (MUST SIGN ARBITRATION AGREEMENT ON PAGE 2)

☐ UNITEDHEALTHCARE SIGNATUREVALUE HARMONY(HMO)	HARMONY HMO PROVIDER GROUP CODE REQUIRED:

DECLINE ENROLLMENT IN THE HARMONY HMO(PARTICIPANT SIGNATURE REQUIRED)

☐ **I decline to enroll in the Harmony HMO _____ (Initials)**	I *decline* to enroll in the SignatureValue Harmony HMO. My eligible dependents and I will remain enrolled in the Flex HMO (Traditional plan) at this time, as offered by the Southern California IBEW-NECA Health Plan. I also understand that the Southern California IBEW-NECA Health Trust Fund Board of Trustees has a fiduciary responsibility to prudently manage the Plan. In order to meet this responsibility, the Trustees periodically review the cost and benefits of various Plans. The Board of Trustees may find it necessary to change, reduce or eliminate benefits.

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

Southern California IBEW-NECA Administrative Corporation

PART 3: FAMILY INFORMATION – PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS CURRENTLY ENROLLED

DEPENDENT INFORMATION:

RELATIONSHIP:	FIRST NAME M.I. LAST NAME	SOCIAL SECURITY NUMBER:	HARMONY PROVIDER GROUP CODE REQUIRED:
☐ DEPENDENT SPOUSE			

DEPENDENT INFORMATION:

RELATIONSHIP:	FIRST NAME M.I. LAST NAME	SOCIAL SECURITY NUMBER:	HARMONY PROVIDER GROUP CODE REQUIRED:
☐ DEPENDENT CHILD			

DEPENDENT INFORMATION:

RELATIONSHIP:	FIRST NAME M.I. LAST NAME	SOCIAL SECURITY NUMBER:	HARMONY PROVIDER GROUP CODE REQUIRED:
☐ DEPENDENT CHILD			

DEPENDENT INFORMATION:

RELATIONSHIP:	FIRST NAME M.I. LAST NAME	SOCIAL SECURITY NUMBER:	HARMONY PROVIDER GROUP CODE REQUIRED:
☐ DEPENDENT CHILD			

PART 4: PARTICIPANT ACKNOWLEDGEMENT (REQUIRED SIGNATURE)

I understand this election will remain in effect so long as I remain eligible, or until I make another election during an 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 changes in the eligibility of my dependents; that the benefits and services of the elected plans 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 Permanente, UnitedHealthcare, Anthem Blue Cross, DeltaCare, United Concordia, Cigna Dental, Vision Service Plan) member and any such Plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

PARTICIPANT SIGNATURE REQUIRED FOR ALL PLAN CHANGES/ENROLLMENTS	DATE SIGNED
X	/ /

PART 5: ARBITRATION AGREEMENT (REQUIRED SIGNATURE)

UNITEDHEALTHCARE HEALTH PLAN (HMO) ARBITRATION AGREEMENT: PLEASE READ AND SIGN

I agree and understand that any and all disputes, including claims relating to the delivery of services under the Pan and claims of medical malpractice (that is, as to whether any medical services rendered under the Health Plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the Plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement 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 binding arbitration.

SIGNATURE REQUIRED FOR UNITEDHEALTHCARE PLAN PARTICIPANT	DATE
X	/ /

FOR OFFICE USE ONLY

NOTES	REASON	MEDICAL	DENTAL	EFFECTIVE DATE OF COVERAGE			DOCUMENTS RECEVIED
				MONTH	DAY	YEAR	
	☐ HARMONY TRANSITION						DATE RECEIVED: _____________ BY: _________________