MEDICAL PLAN ENROLLMENT FORM – RETIREE

SOUTHERN CALIFORNIA IBEW-NECA HEALTH PLAN

100 Corson Street, Suite 200, Pasadena, CA 91103

Mailing Address: P.O. Box 6652, Pasadena, CA 91109

(323) 221-5861 or (800) 824-6935 (Nationwide) Fax No.: (323) 726-3520 website: www.scibew-neca.org

PART 1: MUST SELECT ONE:

☐ **NEW ENROLLMENT** ☐ **CARRIER CHANGE**

PART 2: 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.

RETIREE 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			GENDER ☐ MALE ☐ FEMALE	

MARITAL STATUS

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

PREFFERRED LANGUAGE SELECTION

DO YOU HAVE A PREFERRED LANGUAGE, OTHER THAN ENGLISH? ☐ NO ☐ YES - LANGUAGE: _____ ☐ DECLINE TO RESPOND

PREFERRED LANGUAGE FOR YOUR SPOUSE, OTHER THAN ENGLISH? ☐ NO ☐ YES - LANGUAGE: _____ ☐ DECLINE TO RESPOND

PART 3: PLAN SELECTION

MEDICAL PLAN SELECTION - SELECT ONE PLAN ONLY You and your spouse must select the same coverage option. If you are enrolled as a Non-Medicare participant enrolled in United HealthCare or the Out of Area Plan (offered through United HealthCare) and your spouse is Medicare eligible, your spouse will be covered under the Anthem Medicare Preferred Plan.

OPTIONS	☐ NORMAL RETIREES	☐ EARLY RETIREES
SOUTHERN CALIFORNIA RETIREES ONLY (SELECT ONE PLAN ONLY)	☐ KAISER PERMANENTE SENIOR ADVANTAGE (HMO) #101155-01 **(PLEASE SIGN LEGAL LANGUAGE ON PAGE 3)**	☐ KAISER PERMANENTE EARLY RETIREE (HMO) #101155-01 **(PLEASE SIGN LEGAL LANGUAGE ON PAGE 3)**
	☐ ANTHEM MEDICARE PREFERRED PLAN (PPO) #CA057GRS	☐ UNITEDHEALTHCARE (HMO) HARMONY #252025 **(PLEASE SIGN LEGAL LANGUAGE ON PAGE 3)** UNITEDHEALTHCARE PHYSICIAN CODE REQUIRED:
	☐ NORMAL RETIREES	**☐ EARLY RETIREES**
OUT OF AREA RETIREES ONLY (SELECT ONE PLAN ONLY)	☐ ANTHEM MEDICARE PREFERRED PLAN (PPO) #CA057GRS	☐ UNITEDHEALTHCARE- OUT OF AREA #902027/#355805 **(PLEASE SIGN LEGAL LANGUAGE ON PAGE 3)** UNITEDHEALTHCARE PHYSICIAN CODE REQUIRED:

RETIREE INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

PART 4: FAMILY INFORMATION

ELIGIBILITY STATUS (PARTICIPANT SIGNATURE REQUIRED)

I UNDERSTAND THAT THE SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND BOARD OF TRUSTEES RESERVES THE RIGHT TO REQUIRE ADDITIONAL PROOF AT ANY TIME OF ONGOING DEPENDENT ELIGIBILITY AND MAY CONDUCT PERIODIC AUDITS TO CONFIRM ELIGIBILITY STATUS OF ALL DEPENDENTS. I UNDERSTAND IT IS MY RESPONSIBILITY TO PROMPTLY NOTIFY THE ADMINISTRATIVE TRUST FUNDS OFFICE IN WRITING WITH APPROPRIATE DOCUMENTATION IF THERE IS ANY CHANGE IN MY MARITAL STATUS.

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

TO ADD A SPOUSE, COMPLETE THE SECTION BELOW AND REVIEW THE REQUIRED DOCUMENTS ON PAGE 4

RELATIONSHIP: ☐ SPOUSE – FEMALE ☐ SPOUSE – MALE			DATE OF BIRTH
FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:			☐ COPY OF CERTIFIED MARRIAGE CERTIFICATE INCLUDED

PART 5: MEDICARE INFORMATION

IF YOU ARE TOTALLY DISABLED, OR ENROLLED IN MEDICARE A AND/OR B, PLEASE COMPLETE BELOW:

FIRST NAME	MIDDLE INITIAL	LAST NAME	☐ COPY OF MEDICARE CARD INCLUDED
☐ TOTALLY DISABLED	MEDICARE ☐ A ☐ B		MEDICARE NUMBER OR HICN NUMBER:

IF YOUR SPOUSE IS TOTALLY DISABLED, OR ENROLLED IN MEDICARE A AND/OR B, PLEASE COMPLETE BELOW:

SPOUSE'S FIRST NAME	SPOUSE'S MIDDLE INITIAL	SPOUSE'S LAST NAME	☐ COPY OF MEDICARE CARD INCLUDED
☐ TOTALLY DISABLED	MEDICARE ☐ A ☐ B		MEDICARE NUMBER OR HICN NUMBER:

PART 6: ADDITIONAL HEALTH INSURANCE

IF YOU OR YOUR SPOUSE HAVE OTHER HEALTH COVERAGE, PLEASE COMPLETE:

NAME OF OTHER HEALTH COVERAGE	POLICY NUMBER
INSURED NAME	MEDICARE NUMBER OR HICN NUMBER:

HIPAA SPECIAL ENROLLMENT RIGHTS – IF YOU OR YOUR SPOUSE HAVE OTHER HEALTH COVERAGE, PLEASE SIGN BELOW:

The Retiree Health Summary Plan Description (as of February 1, 2018), Section 3.3.2 "HIPAA Special Enrollment Rights" states: "The only exception to the 30-day initial enrollment deadline detailed in Article 3.3.1: 30-Day Application Deadline is when you and/or your Spouse delay Retiree Health Plan coverage because you and/or your Spouse have other health coverage. This is a Special Enrollment right required under the Health Insurance Portability and Accountability Act (HIPAA) and is only applicable during you and your Spouse's initial enrollment for Retiree Health Plan coverage. You must advise the Administrative Office in writing that you are delaying enrollment in the Retiree Health Plan because you are covered under other health coverage. This written notice must be received by the Administrative Office prior to the end of the 30-day application deadline detailed in (Article 3.3.1: 30-Day Application Deadline), or you will lose your HIPAA Special Enrollment rights. When the other health coverage ends, you must enroll in Retiree Health Plan coverage within 30 days of the loss of the other health coverage. At that time, you must submit written proof of the other coverage, its duration and the date the coverage ended. If you do not enroll within 30 days, you will lose your HIPAA Special Enrollment rights and the ability to elect Retiree Health Plan coverage." **For more information or to request the HIPAA Special Enrollment Rights form, please contact the Administrative Trust Funds Office.**

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

RETIREE INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

PART 7: 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 and UnitedHealthcare) 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	/ /

☐ PLEASE CHECK HERE IF YOU HAVE A POWER OF ATTORNEY FOR HEALTH CARE.
PLEASE SUBMIT COPY OF POWER OF ATTORNEY DOCUMENTS IF NOT PREVIOUSLY SUBMITTED.

PART 8: LEGAL LANGUAGE (REQUIRED SIGNATURE)

KAISER PERMANENTE (HMO) ARBITRATION AGREEMENT: PLEASE READ AND SIGN**

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.

***Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN PARTICIPANT	DATE
X	/ /

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 Plan 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 RECEIVED
				MONTH	DAY	YEAR	
	☐ NEW ENROLLMENT ☐ CARRIER CHANGE						DATE RECEIVED: _____ BY: _____ ☐ MARRIAGE CERT ☐ MEDICARE CARD

Southern California IBEW-NECA Administrative Corporation

RETIREEE INFORMATION			
FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

ADDITIONAL INFORMATION:	
LIST OF ELIGIBLE DEPENDENTS UNDER THE RETIREE HEALTH PLAN:	**PLEASE INCLUDE THE REQUIRED DOCUMENTATION WITH THIS ENROLLMENT FORM:**
SPOUSE	COPY OF CERTIFIED MARRIAGE CERTIFICATE

SAMPLE OF ACCEPTABLE DOCUMENTS BELOW:

Marriage Certificate
A certified marriage certificate proves you did get married and recorded with the county clerk's office. This is an approved verification document.

Marriage License
A marriage license only proves you filed for a license and is **NOT** an approved verification document.

Southern California IBEW-NECA Administrative Corporation