MEDICAL PLAN ENROLLMENT FORM - ACTIVE
ALTERNATE KAISER PERMANENTE PLAN

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:

☐ SOUND 45% & 50% APPRENTICES ☐ MATERIAL HANDLERS ☐ RESIDENTIAL ☐ MAINTENANCE

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.

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	IBEW CARD NUMBER	SOCIAL SECURITY NUMBER
				___ – ___ – ____

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

DATE OF BIRTH	CELLPHONE NUMBER	E-MAIL ADDRESS	GENDER
	( )		☐ MALE ☐ FEMALE

MARITAL STATUS – NOTE: FAILURE TO PROVIDE PROMPT NOTICE OF A CHANGE IN MARITAL STATUS, RESULTS IN PENALITES INCLUDING A LOSS OF ELIGIBILITY.

☐ 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)

ACKNOWLEDGEMENT (REQUIRED SIGNATURE)

I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE INFORMATION I PROVIDED ABOVE IS TRUE AND CORRECT. I AUTHORIZE MY ADDRESS AND PHONE NUMBER TO BE UPDATED SHOULD THESE DIFFER FROM THE CURRENT INFOMRATION ON FILE AT THE TRUST FUNDS OFFICE.

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

PART 4: PLAN SELECTION -

MEDICAL/PRESCRIPTION DRUG PLAN SELECTION –

- ALL PARTICIPANTS ARE AUTOMATICALLY ENROLLED IN THE STANDARD LIFE INSURANCE BENEFIT.

☐ KAISER PERMANENTE (HMO) #101155-03	(YOU MUST LIVE WITHIN THE HMO SERVICE AREA)

PART 5: 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	/ /

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

PART 6: FAMILY INFORMATION – PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS TO BE ENROLLED

CHANGE IN MARTIAL STATUS ACKNOWLEDGEMENT (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. **FAILURE TO PROVIDE PROMPT NOTICE OF A CHANGE IN MARITAL STATUS, RESULTS IN PENALITES INCLUDING A LOSS OF ELIGIBILITY.**

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

SEE LIST OF ELIGIBLE PLAN PARTICIPANTS AND REQUIRED DOCUMENTATION

RELATIONSHIP: ☐ SPOUSE – FEMALE ☐ SPOUSE – MALE			DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED MARRIAGE CERTIFICATE INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED
RELATIONSHIP: ☐ SON ☐ DAUGHTER	☐ STEPSON ☐ STEPDAUGHTER		DATE OF BIRTH	SOCIAL SECURITY NUMBER
FIRST NAME	MIDDLE INITAL	LAST NAME		☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED

PARTICIPANT 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) 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	/ /

FOR OFFICE USE ONLY

NOTES	REASON	MEDICAL	EFFECTIVE DATE OF COVERAGE			DOCUMENTS RECEIVED
☐ NO DEPENDENTS ☐ CARRY ON FILE ☐ NOTIFY VENDOR ☐ OTHER:	☐ NEW ENROLLMENT ☐ CARRIER CHANGE		MONTH	DAY	YEAR	DATE RECEIVED: _____ BY: _____ ☐ MARRIAGE CERT ☐ JUDGMENT OF DISSOLUTION ☐ BIRTH CERT ☐ ADOPTION DOCUMENTS ☐ LEGAL GUARDIANSHIP ☐ FOSTER DOCUMENTS ☐ OTHER:

PARTICIPANT INFORMATION			
FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

ADDITIONAL INFORMATION:

LIST OF ELIGIBLE DEPENDENTS UNDER THE ACTIVE HEALTH PLAN:	PLEASE INCLUDE THE REQUIRED DOCUMENTATION WITH THIS ENROLLMENT FORM:
SPOUSE	CERTIFIED MARRIAGE CERTIFICATE
EX-SPOUSE AND FORMER STEP-CHILDREN	FINAL DIVORCE DECREE, LEGAL SEPERATION, ANNULMENT DOCUMENTS
BIOLOGICAL CHILDREN TO AGE 26	CERTIFIED BIRTH CERTIFICATE/PATERNITY TEST/QMCSO
STEP CHILDREN TO AGE 26	CERTIFIED BIRTH CERTIFICATE
ADOPTED CHILDREN TO AGE 26	COUNTY OR ADOPTION AGENCY DIRECTIVE FOR ADOPTION PLACEMENT
PERMANENTLY DISABLED CHILDREN	CERTIFIED BIRTH CERTIFICATE/PATERNITY TEST/ ADOPTION OR GUARDIANSHIP AFFIDAVIT
CHILD WHO IS A WARD UNDER ORDER OF TEMPORARY OR PERMANENT GUARDIANSHIP OR FOSTER CHILD	LEGAL GUARDIANSHIP DOCUMENTATION OR DIRECTIVE OF A COUNTY DEPARTMENT FOR TEMPORARY GUARDIANSHIP OR FOSTER CHILD PLACEMENT
TEMPORARY DISABLED CHILD	DISABILITY APPLICATION/CERTIFIED BIRTH CERTIFICATE – CHILD SUBJECT TO TEMPORARY OR PERMANENT GUARDIANSHIP

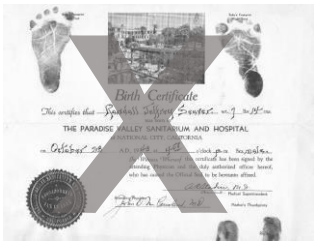
SAMPLE OF ACCEPTABLE DOCUMENTS BELOW:

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.

Birth Certificate
For a birth certificate to be accepted, it must contain the parent(s) name and be issued by the county or state to prove relationship status.

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

Hospital's Certificate of Live Birth
Sometimes with the baby's footprints, it is not a valid proof of identity.



IMPORTANT INFORMATION - NOTIFICATION OF CHANGE IN MARITAL STATUS:

The Active Health Plan Summary Plan Description, Article 4.10 states: "Upon dissolution, divorce, legal separation or annulment, a spouse ceases to be an eligible Dependent on the first day of the month following the month in which the Judgment terminating the marital relationship or providing for legal separation is issued. However, a former spouse may continue to be eligible as a qualified beneficiary under this Plan if COBRA continuation coverage is timely elected as more fully set forth in the COBRA provisions of this Plan. In order to avoid the loss of prospective eligibility, you should notify the Administrative Office of a dissolution, divorce, legal separation or annulment as soon as it occurs. Should neither the Participant nor the former spouse notify the Administrative Office within sixty (60) days of the issuance of the Judgment or termination of marital status, the Participant, former spouse and the spouse's dependents who are no longer the Participant's dependents under the Plan are penalized. The Participant's Hours Bank Reserve shall be charged 120 hours times the number of months thereafter until notice is received. The former spouse and lawful dependents who are no longer your dependents under the Plan lose all COBRA rights (see Article 16.1 COBRA, subpart D). Insurance companies and/or HMO providers may also seek legal damages for the failure to provide prompt notification and the Fund, through the Board of Trustees, shall hold the individual Participant liable for any damages incurred and pursue legal relief against the Participant."
NOTE: "When the hourly rate of contributions being transferred to this Plan is less than the hourly rate of contributions paid directly to this Plan under the Inside Wireman's collective bargaining agreement in effect at the time of the contributions transfer, the hours credited to you under this Plan will be prorated".