SHOPMEN'S IRONWORKERS HEALTH AND WELFARE TRUST FUND

ENROLLMENT FORM

556 South Fair Oaks Avenue #32, Pasadena CA 91101
(800) 973-0615 • (626) 683-8807 Fax

☐ NEW MEMBER **OR** CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ PLAN ☐ ADDRESS ☐ BENEFICIARY ☐ DEPENDENTS

☐ OPEN ENROLLMENT

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

PARTICIPANT DATA

LAST NAME	FIRST NAME	INIT.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)			SEX (M/F)	DATE OF BIRTH
CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED	DATE OF MARRIAGE/DIVORCE	EMPLOYER	DATE OF HIRE	

CHOICE OF PLANS
MEDICAL SELECTION

KAISER PERMAMENTE – GRP #228232

CHOICE OF PLANS
DENTAL SELECTION –

DELTA PMI - GRP #05022-0001

IF YOU SELECT KAISER PERMANENTE AS YOUR MEDICAL PLAN AND WERE PREVIOUSLY COVERED BY KAISER PERMANENTE, PLEASE PROVIDE YOUR KAISER PERMANENTE MEDICAL RECORD NUMBER (IF ANY)_____

FAMILY DATA

FULL NAME	RELATION**	SEX	DATE OF BIRTH	SOCIAL SECURITY #
PARTICIPANT				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

****Relation – Spouse, Son, Daughter, Stepson, Stepdaughter, Other**

Does anyone listed have other health insurance? ☐YES ☐ NO IF YES, COMPLETE BOXES a - e

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address

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 that 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 relationship 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.

Kaiser Permanente and Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, regarding certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my 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.

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION(S)

DATE:_____ **SIGNATURE**_____

(OVER)

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 you will not be permitted to change your Plan until the next annual open enrollment period.

TO ADD OR CHANGE YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION IS 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 LEGAL SPOUSE**
- **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
  - STEP-CHILDREN
  - 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.

The Enrollment Form requires that you name a beneficiary to your *Life Insurance and Accidental Death & Dismemberment Benefits* under the Fund. Be sure to complete it and be specific as to which you are naming – give full name with Jr., Sr., etc., to avoid confusion with anyone else.

BENEFICIARY OF LIFE INSURANCE			
BENEFICIARY'S FULL NAME & ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #
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YOUR SIGNATURE _____ DATE _____

Please submit your marriage certificate if married and/or birth certificates for any dependents you are enrolling