OPERATING ENGINEERS PUBLIC AND MISCELLANEOUS EMPLOYEES HEALTH & WELFARE TRUST FUND

1141 Harbor Bay Parkway, Suite 100 ✶Alameda, California 94502-6594
1-800-251-5014 ✶ Fax 510-863-8373

RETIREE ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **NEW MEMBER** **CHANGE OF:** ☐ **NAME** ☐ **ADDRESS** ☐ **PLAN** ☐ **MARITAL STATUS** ☐ **DEPENDENTS**

PARTICIPANT DATA - EMPLOYEE INFORMATION

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

LAST NAME	FIRST NAME	M.I..	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	GENDER (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	TELEPHONE NUMBER ( )

EMAIL ADDRESS	CELL PHONE NUMBER ( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	DATE OF MOST RECENT MARRIAGE/DIVORCE	EMPLOYER	DATE OF HIRE

CHOICE OF PLANS
MEDICAL SELECTION – CHOOSE ONE:

☐ **ANTHEM**

☐ **KAISER**

IF APPLICABLE, REGARDLESS OF CHOICE OF MEDICAL PLAN, ALL ELIGIBLE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS HAVE:

- DENTAL COVERAGE THROUGH **DELTA DENTAL (800-765-6003)**
- VISION COVERAGE THROUGH VSP **VISION SERVICES PLAN (800-877-7195)**

PLAN PARTICIPANTS

PRESCRIPTION COVERAGE THROUGH **OPTUMRX (855-672-3644)**

KAISER PLAN PARTICIPANTS

- PRESCRIPTION COVERAGE THROUGH KAISER. PARTICIPANTS MUST USE A KAISER PHARMACY.

PERSONAL AND DEPENDENT DATA

PROVIDE THE SOCIAL SECURITY NUMBER OF EACH DEPENDENT YOU ENROLL.
FEDERAL REGULATIONS REQUIRE HEALTH PLANS TO REPORT THE NAMES AND SOCIAL SECURITY NUMBERS OF EVERY COVERED INDIVIDUAL TO THE IRS.

BEFORE ALLOWING A DEPENDENT TO BE ADDED TO THE PLAN, THE TRUST OFFICE REQUIRES ALL DOCUMENTATION SUCH AS MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, DOMESTIC PARTNER CERTIFICATE, DIVORCE, OR REMARRIAGE DOCUMENTS.

Relation*	Last Name	First Name	Gender	Date of Birth	Social Security Number	Receiving Medicare Part A or B	Kidney Transplant or Dialysis
Self						Yes ☐ No ☐	Yes ☐ No ☐
☐ Spouse ☐ Domestic Partner**						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐

***Relation –Son, Daughter, Stepson, Stepdaughter, etc. See the General Eligibility Rules section for definition of "ELIGIBLE DEPENDENTS"**
****Domestic Partner – additional forms required for Domestic Partner eligibility. Contact the Trust Office.**

Complete the section below and enclose a copy of the Medicare card if you or a dependent are enrolled in Medicare

List the individual receiving Medicare	Receiving Part A? Yes ☐ No ☐	Effective Date A: _____/_____/_____
Name:_____	Receiving Part B? Yes ☐ No ☐	Effective Date B: _____/_____/_____

List the individual receiving Medicare Name:_____	Receiving Part A? Yes ☐ No ☐ Receiving Part B? Yes ☐ No ☐	Effective Date A: _____/_____/_____ Effective Date B: _____/_____/_____

Additional Insurance Information

List ANY dependent with an address different than the member's address:

Dependent:	Address:	City	State	ZIP
Dependent:	Address:	City	State	ZIP

List ANY dependent who is entitled to benefits from another group health care, insurance, or pre-paid medical plan:

Dependent:	Insurance Company	Policy Number
Dependent:	Insurance Company	Policy Number

Complete this section if you checked yes to kidney transplant or receiving dialysis

List the individual receiving Dialysis or Transplant	Received Kidney Transplant Yes ☐ No ☐ Receiving Dialysis Yes ☐ No ☐	Date of Transplant: _____/_____/____ Date of first treatment: _____/_____/____

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 Foundation Health Plan, Inc., Arbitration Agreement*

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.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**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.*

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT

By signing below, I declare that have read and understood all information on this enrollment form. I declare that all statements made on this enrollment form are complete and true. I understand that material misrepresentations, omissions, concealment of facts or incorrect statements may void my eligibility for coverage. I understand and consent that information obtained on this enrollment form will be provided to health care organizations for the purpose of providing coverage. I understand that coverage will not be provided until this enrollment is accepted and I meet all eligibility requirements.

Employee Signature _____ **Date**_____

***Before allowing a dependent to be added to the Plan, the Trust Office requires all documentation such as marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents.**

General Eligibility Rules for Dependents

(Subject to all provisions and limitations of the Trust Agreement and Plan Document as well as any rules or regulations)

The Fund considers the following to be Dependents:

- Your lawful spouse
- Your Domestic Partner as further defined below
- Your natural children up through the last day of the month in which they turn 26
- Your stepchildren up through the last day of the month in which they turn 26
- Your legally adopted children (from the time they are placed for adoption) up through the last day of the month in which they turn 26.
- Unmarried children for whom you are the appointed legal guardian as long as they are under 23 years of age and can be claimed as dependents on your federal income tax return
- Your unmarried natural, legally adopted or stepchild who is older than 26 (or 23 if a legal guardianship child) and
  - is prevented from earning a living because of mental or physical disability, AND
  - was disabled and eligible for benefits as a Dependent under this Plan at the time he/she reached the last day of the month in which he/she is turning 26, or in the case of legal guardianship, the last day of the month in which he/she is turning 23, AND
  - is primarily dependent on you for support, AND
  - for whom evidence of the child's dependence and disability was filed with the Trust Fund within 31 days after the child attained the limiting age (and for whom evidence is periodically filed upon request)
- Children as required in a Qualified Medical Child Support order and through the last day of the month in which they turn 26
- Unmarried children below the age of 23 of a Domestic Partner as long as the Domestic Partner qualifies for coverage (See Section 1.18 of the Plan's Rules and Regulations for more information)

Please keep in mind:

- A spouse of a child is not eligible for coverage under the plan
- A Domestic Partner is an individual who has a valid Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership on file with the California Secretary of State. Domestic Partner and the children of the Domestic Partner may enroll in the Plan upon submission of a copy of the Certificate of Registration of Domestic Partnership received from the State of California and payment of the required imputed income taxes to the Fund.
- Before adding an above Dependent to insurance, the Trust Fund Office will request copies of marriage certificates, birth certificates, hospital birth records, domestic partner certifications or other documents necessary to confirm eligibility
- A Dependent that is in the service of the Armed Forces is not eligible as a Dependent but is entitled to purchase COBRA continuation coverage

NOTE THE FOLLOWING:
You can be held liable for benefit payments made based on any incorrect information about your dependents, such as failing to notify the Trust Fund Office if there is a divorce, if your child's status changes, or if an adoption is rescinded. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney fees, Trust Fund Office costs, other administrative costs and reasonable interest.

If you have questions, please contact the Fund's Trust Fund Office at 1-800-251-5014 or email:
PUBLIC-OE3@Zenith-American.com

***ELIGIBILITY FOR ALL PERSONS ENROLLED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS.**