OPERATING ENGINEERS HEALTH & WELFARE FUND
ACTIVE ENROLLMENT FORM

PO BOX 23190 ✶ OAKLAND, CA 94623-0190
1600 HARBOR BAY PKWY #200. ✶ ALAMEDA, CA 94502
1-800-251-5014 ✶ FAX 510-863-8373

PLEASE 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	INIT.	SOCIAL SECURITY NUMBER

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

CITY	STATE	ZIP	TELEPHONE NUMBER ( )

EMAIL ADDRESS (REQUIRED)	CELL PHONE NUMBER (REQUIRED) ( )

MARITAL STATUS	DATE OF MARRIAGE/DIVORCE	EMPLOYER	DATE OF HIRE
☐ SINGLE ☐ MARRIED ☐ DIVORCED			

CHOICE OF PLANS
MEDICAL SELECTION – CHOOSE ONE:

☐ **COMPREHENSIVE**

☐ **KAISER PERMANENTE HMO GRP** #33

CHOICE OF PLANS
DENTAL SELECTION – CHOOSE ONE:

☐ **DELTA DENTAL PPO**

☐ **DELTACARE USA HMO-NOTE: IF YOU ARE NEWLY ELIGIBLE YOU WILL BE AUTOMATICALLY ENROLLED IN DELTACARE USA HMO FOR A MINIMUM OF 12 MONTHS.**

COMPREHENSIVE PLAN PARTICIPANTS PRESCRIPTION COVERAGE IS THROUGH OPTUMRX (855-672-3644)

KAISER PLAN PARTICIPANTS PRESCRIPTION COVERAGE FOR KAISER PARTICIPANTS IS THROUGH KAISER

IF APPLICABLE, REGARDLESS OF CHOICE OF MEDICAL PLAN, ALL ELIGIBLE MEMBER AND THEIR ELIGIBLE DEPENDENTS HAVE VISION COVERAGE THROUGH VSP (800-877-7195)

Personal & Dependent Data

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

*** Relation –Son, Daughter, Stepson, Stepdaughter, Etc. Please see back for definition of "ELIGIBLE DEPENDENTS"**
**** Domestic Partner – the member must apply and qualify separately for Domestic Partner eligibility through the Trust Fund Office.**

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

Please list the individual receiving Medicare

Name:_____

Receiving Part A? Yes ☐ No ☐
Receiving Part B? Yes ☐ No ☐

Effective Date A: ___/___/___
Effective Date B: ___/___/___

Please list the individual receiving Medicare

Name: _____

Receiving Part A? Yes ☐ No ☐
Receiving Part B? Yes ☐ No ☐

Effective Date A: ___/___/___
Effective Date B: ___/___/___

You must complete if you checked yes to kidney transplant or receiving dialysis

Please list the individual receiving Dialysis or Transplant Name:_____	Received Kidney Transplant Yes ☐ No ☐ Receiving Dialysis Yes ☐ No ☐	Date of Transplant:: ___/___/___ Date of first treatment: ___/___/___
Please 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

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

Dependent:_____ **Address:**_____ **City**_____ **State**_____ **Zip**_____

Dependent:_____ **Address:**_____ **City**_____ **State**_____ **Zip**_____

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

Dependent:_____ **Insurance Co.**_____ **Policy No.**_____

Dependent:_____ **Insurance Co.**_____ **Policy No.** _____

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 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, 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 p rovides 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.

DATE:_____ **MEMBER SIGNATURE**_____

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

By signing below, I declare that I 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.

DATE:_____ **MEMBER SIGNATURE**_____

GENERAL ELIGIBILITY RULES

YOUR DEPENDENTS, AS DEFINED BELOW, ARE ALSO ELIGIBLE TO RECEIVE BENEFITS.
Your eligible family members are:

- Your lawful spouse provided you are not divorced.
- If you divorce, your former spouse is no longer an eligible family member on the date of the final divorce decree. You must notify the Trust Fund Office immediately of your divorce.
- Your dependents up to age 26. For purposes of this Plan, your dependents can include:
  - your natural children,
  - your legally adopted children (from the time they are placed for adoption),
  - your stepchildren, or
  - foster children for whom you have been appointed legal guardian by a court.

  In accordance with ERISA Section 609(a)(2)(A), the Plan will provide coverage for a Dependent child of an Employee if required by a Qualified Medical Child Support Order.
- Your children – regardless of age – who were prevented from earning a living because of mental or physical handicap (providing the disabled children were handicapped and eligible as Dependents at the time they reached the limiting age), and are primarily dependent upon the Employee for support. Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 26, and periodically thereafter.
- Qualified Domestic Partners of eligible Employees whose Individual Employers are required by law to provide Domestic Partner health coverage are eligible to enroll in the Plan provided the Employee remits the required tax payments to the Fund. Children of qualified Domestic Partners are eligible provided they meet the Plan's eligibility requirements for Dependent Children. A Domestic Partner and child (ren) of the domestic Partner will remain eligible only so long as the Employee's Individual Employer is legally obligated to provide Domestic Partner health coverage and the required taxes are paid. The term "Domestic Partner" means a person who resides with the Employee in the same residence, is at least 18 years of age and whose relationship with the Employee meets the following requirements:
  1. The Domestic Partner and the Employee have had an intimate, committed relationship of mutual caring for a period of at least 6 months and are each other's sole Domestic Partner;
  2. The Domestic Partner and the Employee share joint responsibility for each other's common welfare and financial obligations and can submit proof of that relationship as required by the Board of Trustees;
  3. Neither the Domestic Partner nor the Employee is married;
  4. The Domestic Partner and Employee are each competent to contract;
  5. The Domestic Partner and Employee are not related by blood closer than would prohibit legal marriage in the State of California;
  6. Any prior domestic partnership of either person has been terminated not less than 6 months prior to the date of the signing of the final declaration of domestic partnership with the Trust Fund Office; and
  7. Application for domestic partnership with the Employee is properly made as required by the Board of Trustees.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TRUST FUND OFFICE AT (800) 251-5014 OR (510) 433-4422.

Important: 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 changes his or her student status, 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.

Before allowing a dependent to be added to the Plan, the Trust Fund Office may ask for documentation such as marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents.

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 ADOPTED BY THE BOARD OF TRUSTEES.

CC: MED CLAIMS _____ CC: KAISER _____ CC: COBRA _____