OPERATING ENGINEERS HEALTH & WELFARE FUND

1600 Harbor Bay Parkway, Suite 200 ✶ Alameda, California 94502-3035
1-800-251-5014 ✶ FAX 510-863-8373

ACTIVE 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 (REQUIRED)	CELL PHONE NUMBER (REQUIRED) ( )

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

CHOICE OF PLANS

MEDICAL SELECTION – CHOOSE ONE:

☐ COMPREHENSIVE

☐ KAISER PERMANENTE HMO GRP #33

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 IS THROUGH KAISER PERMANENTE PARTICIPANTS MUST USE A KAISER PERMANENTE PHARMACY.

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

Personal & 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 on this form 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	Receiving Part A? Yes ☐ No ☐	Effective Date A: ____/____/____
Name:_____	Receiving Part B? Yes ☐ No ☐	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.

DATE:_____ **MEMBER SIGNATURE**_____

***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

YOUR DEPENDENTS, AS DEFINED BELOW, ARE 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. Notify the Trust Fund Office immediately in the event of a divorce.
- Your dependents up to age 26. For purposes of this Plan, your dependents may 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.
- Any change in plans will be effective the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form (per the Summary Plan Description).
- When you enroll in a plan option you must remain in the plan for at least 12 months. An exception will be made only if you elected an HMO and you move out of the HMO service area or it ceases to be available where you live (or the Board approves a change).

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 Office costs, other administrative costs, and reasonable interest.

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.