OPERATING ENGINEERS HEALTH AND WELFARE FUND
MEDICARE RETIREE ENROLLMENT FORM

1640 SOUTH LOOP RD.✶ALAMEDA, CA 94502
1-800-251-5014 ✶ FAX 510-337-3353

☐ **NEW MEMBER OR CHANGE OF:** ☐ **NAME** ☐ **MARITAL STATUS** ☐**PLAN** ☐ **ADDRESS** ☐ **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	DATE OF MARRIAGE/DIVORCE	FORMER EMPLOYER	DATE OF TERMINATION
☐ SINGLE ☐ MARRIED ☐ DIVORCED			

CHOICE OF PLANS
MEDICAL SELECTION – CHOOSE ONE:
- ☐ **COMPREHENSIVE** (1)
- ☐ **PACIFICARE SECURE HORIZONS** (2)(3)
- ☐ **KAISER SR. ADVANTAGE GRP# 7703** (2)(3)
- ☐ **HEALTHNET SR. PLUS** (2)(3)

NOTES:
(1) THIS FORM SERVES AS YOUR ENROLLMENT FORM FOR THESE PLANS.
(2) YOU MUST COMPLETE A SEPARATE FORM IF YOU SELECT THESE PROVIDERS
(3) YOU MUST BE ENROLLED IN BOTH MEDICARE PARTS A & B – SEND A COPY OF YOUR MEDICARE CARD.

ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B?

☐**YES**
EFF. DATE_____
☐**NO**

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

FAMILY DATA

FULL NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY #
PARTICIPANT			
SPOUSE			

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 your 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 arbitration provision is contained in the Evidence of Coverage.

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION

DATE:_____ **SIGNATURE**_____