HAWAII HEALTH & WELFARE TRUST FUND FOR OPERATING ENGINEERS

1141 Harbor Bay Parkway, Suite 100 ✶Alameda, California 94502-6594
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:

☐ HMSA GRP #879-3

☐ KAISER PERMANENTE HMO GRP #**6592**

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

- DENTAL COVERAGE THROUGH HAWAII DENTAL SERVICE – HDS
  800-232-2533
  GRP# 0067-0001
- VISION COVERAGE THROUGH VISION SERVICE PLAN – VSP 800-877-7195
  GRP# 00873005-0006-002

HMSA PLAN PARTICIPANTS' PRESCRIPTION COVERAGE IS THROUGH HMSA **888-948-6109**

KAISER PLAN PARTICIPANTS' PRESCRIPTION COVERAGE IS THROUGH KAISER **800-966-5955**

FOR HMSA USE ONLY
SUB ID NO. _____
EFF DATE _____
GRP# _____
CONT _____ PKG _____
DEPT NO. _____
APP RCV DATE _____
PROC DATE _____
TRX _____

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						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"
**If you are the subscriber of an HMSA Individual plan (Conversion Plan, Individual Business Plan, Plan 6, Student Plan 19, or HPH Individual Conversion Plan) now, do you wish to cancel that membership if this application is accepted? ☐ Yes ☐ No

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		
Name:_____	Receiving Part A? Yes ☐ No ☐	Effective Date A: _____/_____/_____
	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: _____/_____/____

Kaiser Foundation Health Plan Hawaii - Arbitration Agreement *

Binding Arbitration

Except as provided in the Dispute Resolution section of Kaiser Permanente's Guide to Your Health Plan (Guide) or by applicable law, any and all claims, disputes, or causes of action arising out of or related to your Guide or Evidence of Coverage (EOC), its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

This includes but is not limited to any claim asserted:

By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this Agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;

On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this Agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and

By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):

- Kaiser Foundation Health Plan, Inc.,
- Kaiser Foundation Hospitals,
- Hawaii Permanente Medical Group, Inc.,
- The Permanente Federation, LLC,
- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this Agreement, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services (such as temporary restraining orders, and emergency court orders).
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Arbitration Proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation) and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.
In claims involving benefits and coverage due under this Agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, *9 U.S.C. Chapter 1.*

General Provisions
All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).
A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this Agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this Agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this Agreement shall supersede those in any prior Agreement.
Arbitration Confidentiality
Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.
Special Claims Medical Malpractice Claims Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11-19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the "Initiating arbitration" section.
Benefit Claims If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party's claim is frivolous. If the Member Party has any questions about the Member Party's plan, the Member Party should contact Health Plan at 1-800-966-5955.
Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the "Initiating Arbitration" section. If a voluntary election to use binding arbitration is made by a Member Party, the arbitration shall be conducted pursuant to the "Dispute Resolution" section of your Guide or EOC.
External Appeal of Internal Review Decisions If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this Agreement. In addition to the arbitration procedures set forth in this Agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in the "Appeals" section of your Guide or EOC.
Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.
Senior Advantage Member Claims
Complaints and appeals procedures for Senior Advantage Members are described in the Kaiser Permanente Senior Advantage Evidence of Coverage (KPSA EOC). The arbitration provisions of this KPSA EOC apply only to Senior Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this KPSA EOC, irrespective of the legal theory upon which the claim is asserted.
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.

Signature _____ **Date** ____/____/____

KAISER PERMANENTE IMPORTANT ADDRESS INFORMATION:

Subscriber and eligible dependents may enroll if living in the Hawaii service area of Oahu, Maui, and Hawaii (except for ZIP codes 96718, 96772, and 96777) at the time of enrollment. After enrollment, members must continue to live in the Hawaii service area in order to remain a member.

HMSA CONDITIONS OF ENROLLMENT:

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. I further understand that as an HMSA member, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the health/dental plan; and (b) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan. I also agree that HMSA shall set the date on which my health/dental plan coverage shall begin.

KAISER PERMANENTE PRIVACY INFORMATION:

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement, customer service and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our "Notice of Privacy Practices" which is on our Web site, in our medical offices, or by calling our Customer Service Center. If you have questions or concerns about our privacy practices, please contact our Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

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 Plan. Be sure to complete the box marked "CHOICE OF PLANS".

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. Notify the Trust 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

  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. They are not eligible for life insurance benefits.
- 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 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 Office if there is a divorce. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information.

***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.**

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.