PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE FUND
1141 Harbor Bay Parkway, Suite 100✶Alameda, California 94502-6594
1-800-251-5014 ✶ Fax 510-863-8373

NON-MEDICARE RETIREE ENROLLMENT FORM

☐ **NEW MEMBER** **OR** **CHANGE OF:** ☐ **NAME** ☐ **MARITAL STATUS** ☐**PLAN** ☐ **ADDRESS** ☐ **DEPENDENTS**

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

PARTICIPANT DATA				
LAST NAME	**FIRST NAME**	**M.I.**	**FULL SOCIAL SECURITY NUMBER**	
MAILING ADDRESS (STREET OR P.O. BOX)			**GENDER (M/F)**	**DATE OF BIRTH**
CITY	**STATE**	**ZIP**	**TELEPHONE NUMBER** ( )	
EMAIL ADDRESS	**FORMER EMPLOYER**		**DATE OF TERMINATION**	
MARITAL STATUS ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **WIDOWED**			**DATE OF MOST RECENT MARRIAGE/DIVORCE**	
CHOICE OF PLANS **MEDICAL SELECTION – CHOOSE ONE:** ☐ **COMPREHENSIVE** (1) ☐ **KAISER GRP# 7703** (1) **NOTE:** THIS FORM SERVES AS YOUR ENROLLMENT FORM FOR THESE PLANS.			**ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B?** ☐ YES EFFECTIVE DATE_____ ☐ NO	

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

FAMILY 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.

FULL NAME	**RELATION***	**GENDER (M/F)**	**DATE OF BIRTH**	**SOCIAL SECURITY NUMBER**	**OTHER INSURANCE?** (see below)	**ADDRESS SAME AS MEMBER?** (If no, provide below)
SPOUSE					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐

*Relation – Son Daughter, Stepson, Stepdaughter, Adopted child, etc.

LIST ANY ENROLLEE WHO IS ENTITLED TO BENEFITS FROM ANOTHER GROUP HEALTH CARE, INSURANCE, OR PRE-PAID MEDICAL PLAN:

Dependent: _____ Insurance Company _____ Policy # _____
Dependent: _____ Insurance Company _____ Policy # _____
Dependent: _____ Insurance Company _____ Policy # _____
Dependent: _____ Insurance Company _____ Policy # _____

If a dependent child is listed above, I authorize a deduction of $179.00 per child for medical, prescription drug (if applicable), vision care (if applicable) and any additional deduction required for the dental coverage. All provisions of the Pension Deduction Authorization currently on file with the fund for me apply to this authorization. If additional space is required, use the back of this form.

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).

*****THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION. SEE OTHER SIDE*****

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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.

I understand that the Pensioned Operating Engineers Health and Welfare Trust Fund has no enforceable right in, or to my Pension Plan benefit payment or portion thereof, except the payments actually received by the Health and Welfare Fund pursuant to this authorization. I also understand that I may revoke this authorization at any time if I notify the Pension Plan, in writing, of my with to terminate the deduction, and that in the event of such termination the Health and Welfare coverage for myself and/or my dependent child(ren) will also terminate and I will not be able to reenroll at a later date.

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.

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SIGNATURE_____ **DATE**_____