STATIONARY ENGINEERS LOCAL 39 TRUST FUNDS

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www.Local39Benefits.org * L39Enrollments@hsba.com

Date of Hire: ____________
Event Date: ____________
Effective Date: ___________

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: ______________________________ SSN:__________________

ADDRESS: ____ CITY: ________________

STATE: _____ ZIP: __________ DATE OF BIRTH:_______________ EMAIL: ________________________

PHONE NUMBER: (_____) ________________________ GENDER: (Select One) ☐ Male ☐ Female

<u>MEDICAL PLAN</u> (CHOOSE ONE):	**<u>DENTAL</u> (CHOOSE ONE):**
☐ ANTHEM BLUE CROSS (INDEMNITY PLAN - **PPO**)	☐ DELTA DENTAL (INDEMNITY PLAN – **PPO**)
☐ BLUE SHIELD **HMO** PLAN (**<u>Active/Retirees</u>**)	☐ METLIFE DENTAL (**HMO**) **
☐ KAISER PERMANENTE **HMO** PLAN (**<u>Active</u>** Grp# 933-0)	**** Please verify there is a MetLife dentist in your area by visiting www.MetLife.com before electing this option. Refer to the Health & Dental Comparison packet for complete instructions on how to look up a dentist. ****
☐ KAISER PERMANENTE **HMO** PLAN (**<u>Retiree</u>** Grp# 39748-0)	

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION THAT APPLIES**: birth certificate(s), marriage certificate, adoption papers, guardianship papers)

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

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 the Kaiser Permanente Plan **Date**

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE ______________________________ **DATE:** ____________

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