Bay Area Roofers Health Insurance Enrollment / Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

A. ENROLLMENT / CHANGE REASON *(See 'Change Table' on the reverse side of this form for assistance.)*

❑ New Member *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

Bay Area Roofers Health Insurance Plan *(~ PLEASE CHOOSE ONE ~)*: ❑ Kaiser HMO Plan ❑ Anthem Blue Cross PPO Plan

TO BE COMPLETED BY LOCAL UNION		
Health Plan Sponsor: Bay Area Roofers Health & Welfare Trust		Today's Date (mm/dd/yyyy):
Kaiser Group Number: 8527 Anthem Blue Cross Group Number: 277070M001	Enrollment Unit	Effective Enrollment / Change Date (mm/dd/yyyy):

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify):* _____

❑ Name Change *(complete sections A, B, C, D)* From: _____ To: _____

Event Date (mm/dd/yyyy): _____

B. MEMBER Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) | Gender ❑ M ❑ F

Home Address | City | State | ZIP

Work Phone | Home Phone | Email

Ethnicity | Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

❑ Add ❑ Delete ❑ Spouse Gender ❑ M ❑ F ❑ Spouse name: Former last name *(if any)*:		Social Security #: Birth Date (mm/dd/yyyy): Medical Record #:
❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Dependent name: Relationship:		Social Security #: Birth Date (mm/dd/yyyy): Medical Record #:
❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Dependent name: Relationship:		Social Security #: Birth Date (mm/dd/yyyy): Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F Dependent name: Relationship:		Social Security #: Birth Date (mm/dd/yyyy): Medical Record #:

Do any of dependents above live at another address? ❑Yes. ❑No. If yes, complete the following:

Name (Last, First, MI): Address:

D. <u>Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement</u>*

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.

*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

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General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the member must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by Local Union."
4. The Local Union is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The member must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including the Local Union section), the member should retain a copy for his or her records and for use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between Bay Area Roofers Health Trust and Kaiser Permanente.

Instructions for completing new enrollment sections and sections A through D:

To be completed by Local Union: Local Union must complete all fields to ensure we have correct account and enrollment information.

Section A: The member must complete this section.

Section B: The member must complete this section. Use the Change Table (below) for assistance.

Section C: The member must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

Section D: The member must sign and date this section.

Change Table

Add dependent	**Event date**
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent	**Event date**
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

Demographic Change	**Event date**
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.

ADMINISTERED BY UNITED ADMINISTRATIVE SERVICES	**BAY AREA ROOFERS HEALTH & WELFARE PLAN GROUP** **LIFE BENEFICIARY ENROLLMENT APPLICATION** P.O. BOX 5057 SAN JOSE, CA 95150	TRUST FUND USE ONLY ☐ NEW EMPLOYEE ☐ CHANGE ☐ OPEN ENROLL. ☐ COBRA ☐ DELETION
PLEASE PRINT IN INK OR TYPE	LIFE CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE	INSURANCE EFF. DATE _____ DATE _____INITIAL _____

PARTICIPANT INFORMATION

_____ ___/___/___ ___/___/___

LAST FIRST M.I. SOCIAL SECURITY NUMBER DATE OF BIRTH

_____ _____ _____ _____

ADDRESS CITY STATE ZIP CODE

LOCAL NO. _____ ☐ MALE ☐ FEMALE RETIRED ☐ YES ☐ NO EMPLOYER _____

BENEFICIARY INFORMATION

I UNDERSTAND THAT THE BENEFICIARY INDICATED BELOW WILL RECEIVE UPON MY DEATH ALL PROCEEDS FROM THE FOLLOWING:

1) LIFE INSURANCE BENEFIT WITH THE BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
2) AMOUNTS PAYABLE TO ME FROM THE FOLLOWING APPLICABLE VACATION FUND: EAST BAY/ NORTH BAY ROOFERS VACATION PLAN, ROOFERS LOCAL UNION NO. 40 AREA VACATION PLAN OR THE SANTA CLARA COUNTY ROOFERS VACATION PLAN

_____ ___/___/___ _____

NAME (LAST) OF BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF BENEFICIARY CITY STATE ZIP CODE

IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY:

_____ ___/___/___ _____

NAME (LAST) OF CONTINGENT BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF CONTINGENT BENEFICIARY CITY STATE ZIP CODE

IF THE BENEFICIARY IS A MINOR, PLEASE PROVIDE NAME OF GUARDIAN: _____

_____ _____ _____ _____

ADDRESS OF GUARDIAN CITY STATE ZIP CODE

SHOULD I WISH TO DESIGNATE A SEPARATE BENEFICIARY FOR THE AMOUNTS PAYABLE TO ME FROM THE APPLICABLE VACATION PLAN LISTED IN (2) ABOVE, I HEREBY DESIGNATE THE FOLLOWING BENEFICIARY (THE BENEFICIARY LISTED ABOVE WILL CONTINUE TO RECEIVE THE PROCEEDS FROM THE LIFE INSURANCE BENEFIT DESCRIBED IN (1)):

_____ ___/___/___ _____

NAME (LAST) OF BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF BENEFICIARY CITY STATE ZIP CODE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE TRUST FUND ADMINISTRATOR OF ANY CHANGE OF ADDRESS FOR MYSELF OR MY DEPENDENTS. I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION GIVEN IN THIS FORM IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION BY SUBMITTING A NEW FORM. THIS FORM SUPERSEDES ANY PRIOR BENEFICIARY DESIGNATION.

_____ _____

SIGNATURE DATE SIGNED