Laborers Health & Welfare Trust Fund for Southern California
P.O. Box 8024 · El Monte, CA 91734
4399 Santa Anita Avenue, Suite 200, El Monte, CA 91731
T 626-279-3000 · 1-800-887-5679 · F 626-279-3094

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Active Member Enrollment/Change Form Instructions

The number in each circle below represents the Section on the enrollment form.
These instructions are intended to help you complete your Enrollment/Change Form.

1 Member's/Employee's Information

Member/Employee must complete information requested.

- If you are eligible for Medicare Part A or B, provide required Medicare information; have had a kidney transplant or are on dialysis, provide applicable information. Failure to provide this information may delay eligibility.

2 Dependent's Information

- List family members eligible to be covered in Section 2. If additional lines are needed, you may complete an additional Enrollment/Change Form.
- Newborn dependents must be enrolled within 30 days of birth.
- Provide proof of relationship of each dependent you are enrolling: Original Certificate of Marriage and Certificate of Birth of each dependent will be required to establish eligibility.**(Photocopies will not be accepted.)**
- Dependent children up to age 26 are eligible to be covered by the Plan and if not enrolled in this Plan, you may now elect coverage for your eligible dependent children.
- Totally and permanently disabled children may be eligible for continued coverage over age 26, as determined under the terms of the applicable benefit program.
- If you have coverage with Medicare, Medi-Cal or have other medical insurance, you must provide the information so benefits may be coordinated.
- If you are eligible for Medicare Part A or B, provide required Medicare information; have had a kidney transplant or are on dialysis, provide applicable information. Failure to provide this information may delay eligibility.

3 Change of Plan or Status

- Participants making a Plan change must have participated in the Plan you are changing from for at least 12 months.
- Any change of plan or status requires the member's signature and date of signing in the provider's Plan's box.
- **You must list all eligible dependents to be covered when making a plan change.**

4 Life Insurance Designation of Beneficiary(ies)

- Provide information of beneficiary(ies) you would like to designate to receive any benefits in case of your death.
- Your signature and date signed are required.

5 Medical Plan Coverage Selection

- If you are selecting a medical plan for the first time, you should expect to participate in that medical plan for a minimum of 12 months before making another plan change.
- Review and compare each plan's coverage you are being offered in the Summary of Benefits booklet before making your medical plan selection.
- Make your plan selection by checking the appropriate plan's box; complete any information required; and read the plan's agreement.
- Member/Employee must sign and date the plan's agreement.

6 Dental Plan Coverage Selection

- If you are selecting a dental plan for the first time, you should expect to participate in that dental plan for a minimum of 12 months before making another plan change.
- Review and compare each plan's coverage you are being offered in the Summary of Benefits booklet before making your dental plan selection.
- Make your plan selection by checking the appropriate plan's box; complete any information required; and read the plan's agreement.
- Member/Employee must sign and date the plan's agreement.

Prescription Drug Coverage

- Your coverage is provided by Optum Rx. Information about your coverage is in the Summary of Benefits booklet.

7 Vision Coverage

- If you are eligible for vision coverage, your coverage is provided by Anthem Blue View Vision. Information about your coverage is in your Summary of Benefits booklet.

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TRUST FUND USE ONLY
Effective Enrollment/Change Date _____
Date of Hire _____
___Kaiser Permanente –115155 ___ ___
___EPO/PPO Plan – 276444 ___ ___ ___ ___
___SIMNSA Plan – 244
___Delta Dental – 05419 ___ ___ ___ __

ACTIVE ENROLLMENT/CHANGE FORM

Employee, please provide your information in each column below. Your preferred language is ☐ English ☐ Spanish

Member's Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)	Social Security Number

Mailing Address	Local Union

City	State	Zip Code	Gender
			☐ Male ☐ Female

Home (H) Phone	Cell (C) Phone	Accept Text Messages	Work (W) Phone
[ ]	[ ]	☐ Yes ☐ No	[ ]

The best method to contact you is by:
☐ Standard mail ☐ __H __ C __ W Phone ☐ Email at _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you receiving Medicare? ☐ No ☐ Yes (Part A or Part B?)
Part A ☐ Effective Date_____ Part B ☐ Effective Date_____
(If yes, a copy of your Medicare card must be submitted.)
Health Insurance Claim Number (HICN) _____

Dialysis? ☐ Yes ☐ No
Date of Dialysis?_____

Kidney Transplant? ☐ Yes ☐ No
Date of Transplant?_____

SECTION 2 – DEPENDENT INFORMATION.

List spouse and eligible dependents that will be covered under the Plan.
Domestic Partner NOT covered by the Laborers PPO Plan or EPO Plan.

D1

Spouse's/Domestic Partner's Last Name	First Name	Middle Initial	Social Security Number

Date of Birth (mm/dd/yyyy)	Gender	Marriage Date (mm/dd/yyyy)	Kaiser Permanente Domestic Partner Role: (For Kaiser Members)
	☐ Male ☐ Female		☐ Spouse ☐ Domestic Partner

Are you receiving Medicare? ☐ No ☐ Yes (Part A or Part B?)
Part A ☐ Effective Date_____ Part B ☐ Effective Date_____
(If yes, a copy of your Medicare card must be submitted.)
Health Insurance Claim Number (HICN) _____

Dialysis? ☐ Yes ☐ No
Date of Dialysis?_____

Kidney Transplant? ☐ Yes ☐ No
Date of Transplant?_____

Are you covered by or enrolled in another group health plan? ☐ Yes ☐ No

Type of Coverage	Where are your claims sent?	Employer Name
( ) Medical ( ) Dental ( ) _____		

Name of Policy Holder	Group/Policy Number	Policy Effective Date (mm/dd/yyyy)	Employer's Address (City, State, Zip Code)

If more space is needed, please complete an additional Enrollment/Change Form

LB/LB2AE

SECTION 2 – DEPENDENT CHILD(REN) INFORMATION. List eligible dependent child(ren) who will be covered under the Plan.
(If you have more than three [3] dependent children, please complete an additional Enrollment Form.)

D2

Dependent Child's Last Name	First Name	Middle Initial	Social Security Number

Is mailing address different from the employee's or subscriber's address? ☐ Yes ☐ No (If yes, provide address below.)

Date of Birth (mm/dd/yyyy)	Gender	Are you Physically or Mentally Disabled?
	☐ Male ☐ Female	☐ Yes ☐ No

Are you receiving Medicare? ☐ No ☐ Yes (Part A or Part B?)
Part A ☐ Effective Date_____ Part B ☐ Effective Date_____
(If yes, a copy of your Medicare card must be submitted.)
Health Insurance Claim Number (HICN) _____

Dialysis? ☐ Yes ☐ No
Date of Dialysis?_____

Kidney Transplant? ☐ Yes ☐ No
Date of Transplant?_____

Are you covered by or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage	Where are your claims sent?	Employer's Name
( ) Medical ( ) Dental ( ) _____		

Name of Policy Holder	Group/Policy Number	Policy Effective Date (mm/dd/yyyy)	Employer's Address (City, State, Zip Code)

D3

Dependent Child's Last Name	First Name	Middle Initial	Social Security Number

Is mailing address different from the employee's or subscriber's address? ☐ Yes ☐ No (If yes, provide address below.)

Date of Birth (mm/dd/yyyy)	Gender	Are you Physically or Mentally Disabled?
	☐ Male ☐ Female	☐ Yes ☐ No

Are you receiving Medicare? ☐ No ☐ Yes (Part A or Part B?)
Part A ☐ Effective Date_____ Part B ☐ Effective Date_____
(If yes, a copy of your Medicare card must be submitted.)
Health Insurance Claim Number (HICN) _____

Dialysis? ☐ Yes ☐ No
Effective Date of Dialysis?_____

Kidney Transplant? ☐ Yes ☐ No
Effective Date of Transplant?_____

Are you covered by or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage	Where are your claims sent?	Employer's Name
( ) Medical ( ) Dental ( ) _____		

Name of Policy Holder	Group/Policy Number	Policy Effective Date (mm/dd/yyyy)	Employer's Address (City, State, Zip Code)

D4

Dependent Child's Last Name	First Name	Middle Initial	Social Security Number

Is mailing address different from the employee's or subscriber's address? ☐ Yes ☐ No (If yes, provide address below.)

Date of Birth (mm/dd/yyyy)	Gender	Are you Physically or Mentally Disabled?
	☐ Male ☐ Female	☐ Yes ☐ No

Are you receiving Medicare? ☐ No ☐ Yes (Part A or Part B?)
Part A ☐ Effective Date_____ Part B ☐ Effective Date_____
(If yes, a copy of your Medicare card must be submitted.)
Health Insurance Claim Number (HICN) _____

Dialysis? ☐ Yes ☐ No
Effective Date of Dialysis?_____

Kidney Transplant? ☐ Yes ☐ No
Effective Date of Transplant?_____

Are you covered by or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage	Where are your claims sent?	Employer's Name
( ) Medical ( ) Dental ( ) _____		

Name of Policy Holder	Group/Policy Number	Policy Effective Date (mm/dd/yyyy)	Employer's Address (City, State, Zip Code)

SECTION 3 – CHANGE OF PLAN OR STATUS.
When and if you are making a Plan Change, you must have participated in your current plan for 12 months. **If you are making a Status Change or Requesting to remove a Dependent,** check all actions applicable and provide the effective date of the change or the request and the supporting document. If you are already enrolled in a plan and are making any change from your last enrollment, please remember to check all the participating's (medical and/or dental) Plan's Arbitration Agreement, then read and sign the appropriate Plan's arbitration's signature line.

✓	Reason for Election – **Check all that apply**	✓	**Add/Change – Check all that apply** (If making a Plan Change, you must have participated in your current plan for 12 months.)	✓	**Remove – Check all that apply** List Effective Date and Reason below
☐ ☐ ☐	**Enrollment Reason:** **Provide date_____** **and check reason below:** New Hire Loss of Coverage Other Coverage (Explain) _____	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Add Spouse Add Dependent Child Name Change 12-Month Plan Change Address Change Marital Status Change Dependent Child Married Other _____ **Effective Date** _____ **Reason** _____	☐ ☐ ☐ ☐	Remove Spouse Remove Dependent Child Remove (Kaiser Permanente) Domestic Partner Role **Effective Date** _____ **Reason** _____

Continuation of Coverage (Example, COBRA, Cal-COBRA)

COBRA Continuation Coverage for ☐ Employee ☐ Dependents Length of Continuation (months) ☐ 18 ☐ 36 ☐ Other _____ ☐ 29 (Attach your disability determination from Social Security Administration)	Date of Loss Coverage _____ Date of Qualifying Event _____ Continuation of Coverage Expiration Date _____

SECTION 4 – DESIGNATION OF BENEFICIARY(IES). Life Insurance benefit is through Aetna Life Insurance Company of Hartford.

I request that any benefits becoming payable by reason of my death be payable to the following beneficiary(ies). Please provide information of each beneficiary below. If more rows are needed, you may complete an additional form.

1	Last Name	First Name	Middle Initial	Social Security Number	Percentage
	Address (City, State and Zip Code)				Relationship
2	Last Name	First Name	Middle Initial	Social Security Number	Percentage
	Address (City, State and Zip Code)				Relationship

By signing below, I understand that this Designation of Beneficiary is subject to all respective rules of the Laborers Health & Welfare Trust Fund for Southern California.

X _____ _____

Signature of Member Required for Designation of Beneficiary **Date**

SECTION 5 – Medical Plan Selection. (Continued on page 4.)
1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement.
3. (Member) Sign and date selected plan's signature box [**X**].

Medical Plan Options (Choose one): SIMNSA • Kaiser Permanente • Laborers' EPO Plan • Laborers' PPO Plan

☐ **SIMNSA (HMO Plan)** para familias de los empleados que viven en Mexico—Todos los servicios deben ser proporcionados exclusivamente por los proveedores de SIMNSA en Mexico. (No es disponible para los jubilados.)

Al solicitar afiliación como miembro de Sistemas Médicos Nacionales, S. A. para mí y miembros de mi familia que sean elegibles, acepto lo siguiente: 1.Todos los servicios deben ser proporcionados exclusivamente por los proveedores de SIMNSA, salvo urgencias (como explicado en los documentos de membresía). 2. No deben de prestar su tarjeta de membresía a cualquier otra persona, por la cual quedará sujeto a cancelación inmediata y cargos penales. 3. Estoy de acuerdo que SIMNSA obtendrá información médica acerca las personas que se incluyen en esta solicitud con el fin de administrar el Plan. 4. Certifico que la informacion que incluyo en esta solicitud es veridica y correcta y que comprendo los beneficios y reglamentos de este Plan de Salud. 5. Este Plan usa el arbitraje atado exclusivamente para asentar toda disputa que surja bajo este Acuerdo. Se entiende que cualquier disputa en cuanto a negligencia médica si en caso de que algún servicio medico rendido bajo este contrato era innecesario, no autorizado, inapropiado, negligente o incompetentemente rendido, será determinado por la sumisión al arbitraje como es proporcionado por la ley de California, y no por un pleito o un proceso tribunal excepto como la ley de California estipula para la revisión judicial de actos de arbitraje. Ambos partidos al aceptar este contrato rinden su derecho constitucional para tener cualquier disputa decidida en un tribunal de la ley ante un jurado, en lugar aceptan el uso del arbitraje. Para más informacion favor de referirse a su Constancia de Cobertura y Elegibilidad (CCE).

X _____ _____

Firma del empleado es necesaria para el plan SIMNSA **Fecha**

SECTION 5 – Medical Plan Selection. (Continued from page 3.)	1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement. 3. (Member) Sign and date selected plan's signature box **[X]**.

☐ **Kaiser Permanente (HMO) Plan (115155)** If selecting Kaiser Permanente, please read the arbitration below before signing.

If you or your dependents were issued a Kaiser Permanente Medical Record Number, please write your number below.

Medical Record Number Employee	Medical Record Number Dependent 1 (Spouse/DP)	Medical Record Number Dependent 2	Medical Record Number Dependent 3	Medical Record Number Dependent 4

Kaiser Foundation Health Plan 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.

X _____ _____

Signature Required for Kaiser Permanente Plan **Date**

☐ **Laborers EPO Plan**

Participants in the Laborers EPO Plan must receive services from providers, and at laboratories and facilities participating in the Anthem Blue Cross Prudent Buyer (Prudent Buyer) network. Participants receiving services from non-participating providers, at non-participating laboratories or at non-participating facilities with the Prudent Buyer network will be responsible for any out-of-pocket expenses not covered by the Plan.

☐ **Laborers PPO Plan**

Participants in the Laborers PPO Plan may receive less out-of-pocket expenses when receiving services from providers, at laboratories and facilities participating in Anthem Blue Cross Prudent Buyer (Prudent Buyer) network.

Laborers Health Plan Agreement:

If the Trust Fund pays benefit for me or on behalf of me or any person listed as a dependent on this form when I am or such person is not, in fact, eligible to the benefits or if the Trust Fund otherwise mistakenly pays benefits, I agree to promptly reimburse the Trust Fund in full for any such monies paid. I also agree that the Trustees, in their sole discretion may deduct or offset any such monies from my future benefits. If the Trust Fund files any legal action against me to recover any such monies, I agree to pay all attorney's fees and cost of the Trust Fund, whether or not such as an action proceeds to judgment.

The Trustees reserve the right to change, add or eliminate benefits at any time.

The Laborers EPO Plan uses the Anthem Blue Cross Prudent Buyer Plan (Prudent Buyer) network. I understand benefits will only be paid if I use participating providers, laboratories and facilities within the Plan's network. Exceptions may be considered in the event of an emergency. I understand when using Non-Participating Providers, Non-Participating Laboratories or Non-Participating Facilities and Other Health Care Providers, I am responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage copay.

The Laborers PPO Plan uses the Prudent Buyer network. I understand when using Non-Participating Providers, Non-Participating Laboratories or Non-Participating Facilities and other Health Care Providers, I am responsible for any difference between the covered expense and the actual charges, as well as any deductible and percentage copay. I also understand any preventive service received outside of the network will not be covered.

X _____ _____

Signature Required for Laborers Health Plan **Date**

SECTION 6 – Dental Plan Selection.	1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement. 3. (Member) Sign and date selected plan's signature box [**X**].

Dental Plan Options (Choose one): • Laborers' PPO Dental Plan • DeltaCare, Delta Dental's (HMO) Plan

Participants must meet the Laborers Health and Welfare Plan's eligibility requirements for dental coverage to receive dental benefits. Please refer to the Benefit Chart for Apprentices in the blue Summary of Benefits booklet for Active participants or the Summary of Plan Description (SPD).

☐ **Laborers PPO Dental Plan** **(If selecting the PPO dental plan, your signature is required on the signature line for the Laborers PPO Dental Plan).**

Laborers Dental Plan Agreement:

If the Trust Fund pays benefit for me or on behalf of me or any person listed as a dependent on this form when I am or such person is not, in fact, eligible to the benefits or if the Trust Fund otherwise mistakenly pays benefits, I agree to promptly reimburse the Trust Fund in full for any such monies paid. I also agree that the Trustees, in their sole discretion may deduct or offset any such monies from my future benefits. If the Trust Fund files any legal action against me to recover any such monies, I agree to pay all attorney's fees and cost of the Trust Fund, whether or not such as an action proceeds to judgment.

The Trustees reserve the right to change, add or eliminate benefits at any time.

The Laborers PPO Plan uses the Prudent Buyer network. I understand when using Non-Participating Providers, Non-Participating Laboratories or Non-Participating Facilities and other Health Care Providers, I am responsible for any difference between the covered expense and the actual charges, as well as any deductible and percentage copay. I also understand any preventive service received outside of the network will not be covered.

X _____ _____

Signature Required for Laborers PPO Dental Plan **Date**

☐ **DeltaCare, Delta Dental's (HMO) Plan** **(If selecting the HMO dental plan, your signature is required on the signature line for the DeltaCare, Delta Dental's [HMO] Plan below.)**

	1st Choice Dental Office	Address of Dental Office	2nd Choice Dental Office	Address of Dental Office
Employee				
Spouse (D1)				
Child (D2)				
Child (D3)				
Child (D4)				

Delta Dental Disclosure (Refer to the complete Combined *Evidence of Coverage* and Disclosure Form from Delta Dental for more details.)

You must select a provider from the network listing and indicate that on your Enrollment/Change Form (new enrollees). You may elect to change providers within the network by contacting DeltaCare's Customer Service Department at 1-800-422-4234.

Delta Dental's co-payment for your benefits is shown in the DeltaCare USA Provided by Delta Dental of CA / *Evidence of Coverage* under the caption titled "*Highlights of your DeltaCare USA Program* ." If dental services are provided by a DeltaCare USA dentist, you are responsible for the co-payment only. If the dental services you receive are provided by a dentist who is not a DeltaCare USA dentist, you are responsible for the full cost of the treatment.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care (noted in the evidence of coverage booklet) must be preauthorized by Delta Dental to be covered by your DeltaCare USA program. DeltaCare's Customer Service Department can be reached at 1-800-422-4234.

X _____ _____

Signature Required for DeltaCare, Delta Dental's (HMO) Plan **Date**

SECTION 7 – Blue View Vision Plan.	Participants must meet the Laborers Health and Welfare Plan's eligibility requirements for vision coverage to receive vision benefits. Please refer to the Benefit Chart for Apprentices in the blue Summary of Benefits booklet for Active participants or the Summary of Plan Description (SPD).

Participants in the Kaiser Permanente Plan may receive an eye exam at a Kaiser Permanente Facility to provide a prescription for eye wear or contact lenses. Eligible participants in the HMO, EPO and PPO plans should refer to the Blue View Vision's benefit chart for eye wear or contact lenses in the blue Summary of Benefits booklet. **Reimbursement.** For reimbursement of your vision claim, please complete the Blue View Vision Reimbursement Form available in back of the blue Summary of Benefits booklet. Reimbursement claims must be sent to Blue View Vision. (See address located at the bottom of the Blue View Vision Claim Form.)