NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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BLUE SHIELD OF CALIFORNIA PPO / HMO *ACTIVE* ENROLLMENT/CHANGE FORM ("FORM")

You must complete numbers 1 through 17 in blue or black ink. Form may be considered invalid if it: (a) is not completed in full or (b) contains any type of alterations (e.g. correction tape, white out, etc.). Invalid Forms will be returned to you for completion prior to processing. Read instructions on reverse side prior to completing this Form.

IMPORTANT NOTE – DO NOT DELAY: Full completion and return of this Form is mandatory for all Participants for enrollment, changes, and upon request by the Trust Fund Office. For any Dependents listed on the Form, legal documentation establishing the Participant's relationship to the Dependent (e.g. certified birth certificate, certified marriage certificate, etc.) needs to be on file with the Trust Fund Office. If you have not already submitted such documentation for any Dependent listed on this Form, you should attach a copy when you submit the completed Form.

PARTICIPANT INFORMATION

1. Last Name, include Suffix (if applicable)	2. First Name	3. M.I.	4. Sex	5. Date of Birth	6. Social Security Number
			❑ M ❑ F	/ /	- -

7. Mailing/Residence Address | **City** | **State** | **Zip Code**

8. Marital Status
❑ Never Married ❑ Separated (See Reverse Side)
❑ Married ❑ Divorced ❑ Divorced and Remarried
❑ Widowed ❑ Widowed and Remarried

Applicable Date of Marriage / Separation / Divorce (Circle One)
_____/_____
Month **Year**

9. Are you Eligible for Medicare?
❑ Yes ❑ No
If yes complete the following, and attach a copy of your Medicare Card
Part A ❑ Part B ❑
Effective Date(s) _____ / _____
Month **Year**

10. Participant's
Primary Phone ( ) -
Secondary Phone ( ) -
Email _____

HEALTH PLAN SELECTION

This Selection is for your entire family. Important: If you are enrolled/enrolling in the Blue Shield of California HMO Plan, you must designate a Primary Care Physician (PCP) and an IPA/Medical Group. If you fail to complete this section, Blue Shield will automatically assign you to a PCP and IPA/Medical Group. You will be required to schedule appointments/services through your PCP/IPA Medical Group. **The Blue Shield of California HMO Plan option has limitations in their coverage service area.** To enroll in the Blue Shield of California HMO Plan, the Participant and all of their eligible Dependents must reside in a service area provided for under the Blue Shield of California HMO Plan.

11. ❑ Blue Shield of California PPO Plan (Nationwide coverage) **or** ❑ Blue Shield of California HMO Plan (Limited coverage area in California)
PCP (Primary/Personal Care Physician): _____ IPA/Medical Group Name: _____

DEPENDENT INFORMATION

When a Participant completes this Form, ALL Dependents eligible to be enrolled and maintained in the Plan must be listed. Failure to list any/all eligible Dependents on this Form will result in termination of their Health and Welfare coverage. Refer to the reverse side for definitions of eligible Dependents.

12. Lawful Spouse / Domestic Partner (Complete All Sections)
❑ Lawful Spouse
❑ Domestic Partner

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address | **City** | **State** | **Zip Code**

Does this Dependent Reside with the Participant? ❑ Yes ❑ No

Marital Status
❑ Never Married ❑ Separated (♦1 – See Reverse Side)
❑ Married ❑ Divorced ❑ Divorced and Remarried
❑ Widowed ❑ Widowed and Remarried

Applicable Date of Marriage / Separation / Divorce (Circle One)
_____/_____
Month **Year**

Is this Dependent Eligible for Medicare? ❑ Yes ❑ No
If yes complete the following and attach a copy of this Dependent's Medicare Card
Part A ❑ Part B ❑ Effective Date(s) _____ / _____
Month **Year**

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. This Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____ IPA/Medical Group Name: _____

13. Dependent Child (ONE) (Complete All Sections)
❑ Natural Child
❑ Stepchild
❑ Other - Define:

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address | **City** | **State** | **Zip Code**

Is this Dependent Disabled? ❑ Yes ❑ No

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. This Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____ IPA/Medical Group Name: _____

14. Dependent Child (TWO) (Complete All Sections)
❑ Natural Child
❑ Stepchild
❑ Other - Define:

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address | **City** | **State** | **Zip Code**

Is this Dependent Disabled? ❑ Yes ❑ No

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. This Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____ IPA/Medical Group Name: _____

15. Dependent Child (THREE) (Complete All Sections)
❑ Natural Child
❑ Stepchild
❑ Other - Define:

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address | **City** | **State** | **Zip Code**

Is this Dependent Disabled? ❑ Yes ❑ No

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. This Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____ IPA/Medical Group Name: _____

IMPORTANT NOTICE: I apply for Health and Welfare coverage through the Plan for myself and the person(s) listed and agree that we shall abide by the provisions of the Northern California Pipe Trades Trust Funds, Blue Shield of California, Delta Dental of California, and Vision Service Plan (VSP).

I understand that I will be liable for any claims incurred and/or premiums paid, including costs and attorneys' fees incurred, that result from inaccurate or false statement(s), enrolling or maintaining enrollment of ineligible Dependent(s), and/or failure to notify the Trust Fund Office within 30 days of any change of information listed on the Form. In addition to the Agreement listed above, I also certify that I have read and understand both sides of the Form, the Enrollment Procedures and the Dependent Eligibility Definitions.

Eligibility for all persons listed on this two sided Form are subject to all provisions and limitations of the Trust Agreement and Plan Document (as amended) as well as to any rules and regulations adopted by the Board of Trustees. Please see your Summary Plan Description for details.

I acknowledge that the information provided on this Form is accurate and I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

16. SIGNATURE OF PARTICIPANT REQUIRED _____ **17. DATE** _____

TRUST FUND OFFICE USE ONLY: ❑ Audit ❑ Change ❑ COBRA ❑ New Participant | **EFFECTIVE DATE:**

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ENROLLMENT PROCEDURES

IMPORTANT INFORMATION - Please read prior to completing the Enrollment/Change Form ("Form").

- The Form must be completed to enroll you and your Dependent(s), if applicable, for Health and Welfare coverage under the Northern California Pipe Trades ("NCPT") Health and Welfare Plan within 30 days from the date you become eligible or you acquire a new Dependent (e.g. marriage, birth, adoption, etc.). You are required to notify the Trust Fund Office by full completion of a new Form within 30 days of a change in life circumstances (e.g. marriage, separation, divorce, Participant, Spouse, Domestic Partner and/or Dependent Child(ren) change of address, new Dependents, Dependent and Domestic Partnership status changes, etc.).
- Plan rules allow an eligible Participant to change their Health Plan selection once in any 12 month period. However, a Participant must be eligible for Health Plan coverage and remain in the selected plan for the next 12 months, unless the Participant moves out of the Plan's service area. If special circumstances exist, a change may be approved.
- Generally, if your fully completed Form and any Plan required documentation are received by the 20th of the month, changes will be effective the first of the month following receipt of the Form. Failure to provide Plan required documentation may cause a delay in processing any changes and/or enrollment. Contact the Trust Fund Office for additional information and/or to confirm your exact effective date(s).
- If you and/or your eligible Dependent(s) incur(red) claims prior to your anticipated effective date, contact the Trust Fund Office immediately. Retroactive coverage may be limited due to the Carriers retroactive limitations/rules.
- It is both the Participant's and Dependent's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. Failure to notify the Trust Fund Office within 30 days of a Dependent's change in eligibility status may be considered fraud and could result in requests for reimbursement of any overpayments and/or loss of certain extensions of coverage for the ineligible Dependent(s). The Participant and ineligible Dependent(s) may also be responsible for attorney's fees or other costs incurred by the Plan as a result of maintaining an ineligible Dependent(s).
- ***ENROLLMENT OF CERTAIN DEPENDENTS (E.G. DOMESTIC PARTNER, CHILDREN OF DOMESTIC PARTNER, ETC.) MAY BE CONSIDERED A TAXABLE EVENT. REFER TO THE SUMMARY PLAN DESCRIPTION, PLAN NOTICES, AND/OR APPLICABLE FORMS.***

DEPENDENT ELIGIBILITY DEFINITIONS If you are eligible for Health and Welfare coverage, the following Dependents may be covered:	**PLAN REQUIRED DOCUMENTS** **FOR ENROLLMENT:**	**FOR TERMINATION:**
LAWFUL SPOUSE (including opposite-sex and same-sex spouse) who resides (principal residence) with the Participant and is not separated from the Participant in any form (e.g. divorce or legal separation, unofficial separation where Participant no longer lives with spouse, etc.). **A spouse who does not reside with the Participant would not meet the Plan definition of an eligible Dependent.** For Administration purposes, the Plan will consider the date of separation to be the earlier of: (1) the date that a Participant and spouse separate by joint decision regardless of whether they still reside at the same physical residence; or (2) the date that a Participant and spouse no longer reside on a full-time basis at the same physical address; or (3) the separation date listed on any court filing for Marital Dissolution or Legal Separation.	Updated Form, copy of Certified Marriage Certificate and Final Divorce Decree or Death Certificate from any previous marriages (if applicable).	Updated Form, written notice of any change in life circumstances and/or separation in any form (e.g. legal separation, separation by joint decision, no longer residing with the Participant, etc.), copy of Legal Separation documents, Marital Settlement Agreement (MSA) and Qualified Domestic Relations Order (QDRO) and copy of Final Divorce Decree (as they become available). Contact the Trust Fund Office.
DOMESTIC PARTNER who resides with the Participant and meets all of the conditions described in the NCPT Trust Fund "Affidavit of Domestic Partnership". A Domestic Partner under the Laws of a country other than the United States is not a lawful Dependent unless such person independently qualifies as a Domestic Partner as provided in the NCPT Health and Welfare "Affidavit of Domestic Partnership". **Domestic Partners are permitted by the Plan for Active Participants only**.	Updated Form, notarized NCPT Health and Welfare Affidavit of Domestic Partnership signed by both Participant and Domestic Partner and Final Divorce Decree or Death Certificate for any previous marriages (if applicable).	Updated Form and written notice of any change or termination of the Domestic Partner relationship. Contact the Trust Fund Office.
CHILDREN THROUGH 25 YEARS OF AGE MAY INCLUDE THE PARTICIPANT'S: • **Natural Children.** • **Stepchildren.** The Plan has no obligation to continue coverage for a stepchild(ren) once the stepchild(ren)'s natural parent (Participant's spouse) separates, in any form, from the Participant. • **Legally Adopted Children.** If a Participant has not legally adopted a child(ren), the Plan has no obligation to continue coverage for a child(ren) once the spouse who legally adopted the child separates, in any form, from the Participant. • **Children for whom the Participant has been Appointed Legal Guardian.** The Plan might consider a child(ren) for whom the Participant's Lawful Spouse has been Court-Appointed as sole legal guardian. Refer to the Summary Plan Description or contact the Trust Fund Office for Plan rules and details.	Updated Form, copy of Certified Birth Certificate and, if applicable, legally recognized documentation establishing custody and responsibility for health coverage (e.g. court order).	Updated Form. Contact the Trust Fund Office.
DOMESTIC PARTNER'S CHILDREN THROUGH 25 YEARS OF AGE must be the natural Children of an eligible and enrolled Domestic Partner.	Updated Form, copy of Certified Birth Certificate which names the eligible and enrolled Domestic Partner as the Natural Parent.	Updated Form and written notice of any change or termination of the Domestic Partner relationship. Contact the Trust Fund Office.
UNMARRIED PERMANENTLY DISABLED NATURAL CHILDREN whose coverage would otherwise terminate due to attainment of age 26 may continue to be eligible, providing the Dependent meets Plan rules as outlined in the Summary Plan Description and any subsequent Summary of Material Modifications to the Plan.	Contact the Trust Fund Office.	Contact the Trust Fund Office.

HOW TO COMPLETE THE FORM

- Complete numbers 1 through 10 with the Participant's information.
- Choose a Health Plan Selection in number 11. Your eligible Dependent(s) will be enrolled in the same Health Plan.
- Complete numbers 12 through 15 (if applicable) and provide the Plan required documents. You MUST fully complete all subsections. **Attach additional Form(s) to enroll additional Dependents.**
- Read the **Blue Shield of California Agreement** and **IMPORTANT NOTICE** above the signature line before you complete numbers 16 and 17.
- If you and/or any Dependent(s) have **Medicare, submit a copy of the card(s) with this Form.**

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