NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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KAISER PERMANENTE HMO *ACTIVE* ENROLLMENT/CHANGE FORM ("FORM")

You must complete numbers 1 through 18 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, whiteout, 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
❑ 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: <u>The Kaiser Permanente HMO Plan option has limitations in their coverage service area.</u> To enroll in the Kaiser Permanente HMO Plan, the Participant and all of their eligible Dependent(s) must reside within the State of California as provided for under the Kaiser Permanente HMO Plan.

11. ☒ Kaiser Permanente HMO Plan (Coverage area within California)

DEPENDENT INFORMATION

<u>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.</u> 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
❑ 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

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

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

<u>Kaiser Foundation Health Plan, Inc., 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*.

15. Signature Required for Kaiser Permanente Plan _____ **16. Date** _____

Disputes arising from the 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.

<u>IMPORTANT NOTICE</u>: 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, Kaiser Permanente, 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 Arbitration 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.

17. SIGNATURE OF PARTICIPANT REQUIRED _____ **18. DATE** _____

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

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, Divorce/Dissolution, Legal Separation, 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 who is not Divorced or Legally Separated from the Participant. A Spouse becomes eligible as of the date of marriage, provided you have submitted an update Form adding your Spouse along with a copy of your certified marriage certificate within 30 days of the date of marriage. If an updated Form and required documentation are not received within 30 days of the date of marriage, enrollment in the Plan for your Spouse will not be effective until the first of the month following receipt of the required documents. A former Spouse is NOT eligible for coverage as a Dependent under the Plan and a Participant may not enroll an Ex-Spouse, even if they are legally required to maintain coverage.	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 a copy of Legal Separation documents, Marital Settlement Agreement (MSA) and/or 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 is Divorced/Legally Separated 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 Divorces or Legally Separates 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.
- Confirm Health Plan Selection in number 11. Your eligible Dependent(s) will be enrolled in the same Health Plan.
- Complete numbers 12 through 14 (if applicable) and provide the Plan required documents. You MUST fully complete all subsections. **Attach additional Form(s) to enroll additional Dependents.**
- Read the **Kaiser Foundation Health Plan Arbitration Agreement** and **IMPORTANT NOTICE** above each signature line before you complete numbers 15 through 18.
- If you and/or any Dependent(s) have **Medicare, submit a copy of the card(s) with this Form.**

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