

NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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KAISER PERMANENTE HMO RETIREE 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, 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 <input type="checkbox"/> M <input type="checkbox"/> F	5. Date of Birth / /	6. Social Security Number - -	
7. Mailing/Residence Address		City	State	Zip Code		
8. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Separated (See Reverse Side) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Divorced and Remarried <input type="checkbox"/> Widowed <input type="checkbox"/> Widowed and Remarried		Applicable Date of Marriage / Separation / Divorce (Circle One) ____/____/____ Month Year	9. Are you Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete the following, and attach a copy of your Medicare Card Part A <input type="checkbox"/> Part B <input type="checkbox"/> Effective Date(s) ____/____/____ Month Year		10. Participant's Primary Phone () - Secondary Phone () - Email _____	

HEALTH PLAN SELECTION

This Selection is for your entire family. Important: **The Kaiser Permanente HMO Plan option has limitations in their coverage service area.** To enroll in the Kaiser Permanente HMO Plan, the Participant and all of their eligible Dependent(s) must reside in the Northern California Service Area provided for under the Kaiser Permanente HMO Plan.

11.	<input checked="" type="checkbox"/> Kaiser Permanente HMO Plan (Coverage is limited to the Northern California Service Area only)
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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 (Complete All Sections)	Last Name, include Suffix (if applicable)	First Name	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number - -
	Address City State Zip Code					
	Does this Dependent Reside with the Participant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Separated (*1 – See Reverse Side) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Divorced and Remarried <input type="checkbox"/> Widowed <input type="checkbox"/> Widowed and Remarried	Applicable Date of Marriage / Separation / Divorce (Circle One) ____/____/____ Month Year	Is this Dependent Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete the following and attach a copy of this Dependent's Medicare Card Part A <input type="checkbox"/> Part B <input type="checkbox"/> Effective Date(s) ____/____/____ Month Year		

13. Dependent Child (ONE) (Complete All Sections) <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other - Define:	Last Name, include Suffix (if applicable)	First Name	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number - -
	Address City State Zip Code					
	Is this Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No					

14. Dependent Child (TWO) (Complete All Sections) <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other - Define:	Last Name, include Suffix (if applicable)	First Name	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number - -
	Address City State Zip Code					
	Is this Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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*.

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**

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, 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 RETIRED PARTICIPANT REQUIRED _____ 18. DATE _____

TRUST FUND OFFICE USE ONLY: <input type="checkbox"/> Audit <input type="checkbox"/> Change <input type="checkbox"/> IN / OUT of CA / USA <input type="checkbox"/> COBRA <input type="checkbox"/> New Retiree	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 Dependents, 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 and/or Dependent Child(ren) change of address, new Dependents, Dependent 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).
- The Plan recommends that you and/or your Dependent(s) enroll in Medicare Parts A and B of the Federal program during the three (3) months before the month in which you and/or your Dependent(s) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. Moreover, if you and/or your Dependent(s) are under age 65 but eligible for Medicare, you and/or your Dependents must also enroll for Parts A and B. Proof of Medicare status is required to maintain your coverage and avoid penalties in premiums. Retirees and/or Dependent(s) who are Medicare eligible but fail to enroll in Medicare Parts A and/or B are subject to an additional monthly premium to help offset the additional costs imposed on the Plan for Medicare eligible individuals who elected not to enroll. The rate of this additional premium is determined by the Board of Trustees and will likely increase in the future.

DEPENDENT ELIGIBILITY DEFINITIONS	PLAN REQUIRED DOCUMENTS	
If you are eligible for Retiree Health and Welfare coverage, the following Dependents may be covered:	FOR ENROLLMENT:	FOR TERMINATION:
<p>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.). <u>A spouse who does not reside with the Participant would not meet the Plan definition of an eligible Dependent.</u> 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.</p>	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.
<p>CHILDREN THROUGH 25 YEARS OF AGE MAY INCLUDE THE PARTICIPANT'S:</p> <ul style="list-style-type: none"> 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.
<p>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.</p>	Contact the Trust Fund Office.	Contact the Trust Fund Office.

HOW TO COMPLETE THE FORM

- Complete numbers 1 through 10 with the Retired 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.**

DISENROLLMENT PROCEDURES

If you wish to dis-enroll yourself and/or your eligible Dependent(s), a written request must be submitted to the Trust Fund Office.

If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Trust Fund Office.

If you are eligible for Medicare Benefits you must contact the Trust Fund Office for the required forms.

IMPORTANT: BECAUSE MEDICARE REQUIRES TIME TO PROCESS YOUR DISENROLLMENT REQUEST, FAILURE TO DISENROLL TIMELY MAY RESULT IN A LAPSE IN UTILIZING YOUR MEDICARE BENEFITS.