LABORERS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1498
Telephone: 707-864-2800 or Toll-Free at 800-244-4530
Email: customerservice@norcalaborers.org
Website: www.norcalaborers.org

FUND OFFICE USE ONLY (640)
EFF. DATE:
HCID: **LA**
ELIGIBILITY CODE/GROUP NO.:

RETIRED PLAN APPLICATION FORM

RETIREE INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST

RESIDENCE ADDRESS (not Post Office Box)	CITY	STATE	ZIP CODE

TELEPHONE NUMBER	LOCAL UNION	DATE OF BIRTH			SEX	MARITAL STATUS
		MONTH	DAY	YEAR		
( )					☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED RETIREE? ☐ NO

☐ YES: PROVIDE THE DECEASED RETIREE'S SOCIAL SECURITY NUMBER:

DEPENDENT INFORMATION (List all eligible dependents to be enrolled)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM RETIREE)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	**Kaiser** Medical Record Number (see ** below)
SPOUSE	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				

**** Kaiser Medical Record Number** - If you selected a ***Kaiser Plan*** and any of your dependents listed above is currently or formerly a Kaiser member, write the Medical Record Number, if known, for each dependent and write **YOUR** Kaiser Medical Record Number here ☞ _____.

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER INSURANCE? ☐ NO

☐ YES: PROVIDE NAME OF THE INSURANCE COMPANY:

PLAN OPTIONS FOR INDIVIDUALS WHO ARE NOT ELIGIBLE FOR MEDICARE (Check only one box)

☐ A **Kaiser Permanente – Group 603307**

☐ B **Laborers Direct Payment Plan**

— Please complete both sides of this form —

PLAN OPTIONS FOR MEDICARE-ELIGIBLE INDIVIDUALS (Check only one box)

Please read the following important notice before making an election. The Plan's term "**Eligible for Medicare**" means an individual who is **qualified to enroll** in both Federal Medicare Parts A and B **whether or not** the individual has actually enrolled for Medicare. If you are an "**Eligible for Medicare**" individual who did not enroll in both Medicare Parts A and B:

(1) You cannot elect Kaiser below as they require the individual to be enrolled in both Parts A and B.

(2) If you elect the Laborers Direct Payment Plan, the Plan will charge you the Medicare premium rate whether or not you enrolled in Medicare Part B, and, will **estimate** the benefits payable under Medicare when your claims are paid.

After you file this application, it is your obligation to notify the Fund Office immediately of any changes to your Medicare enrollment status. Please answer the following questions and make your Plan election below:

YOUR Medicare effective date

PART A: MONTH: _____ YEAR: _____

PART B: MONTH: _____ YEAR: _____

PART D: MONTH: _____ YEAR: _____

Your SPOUSE Medicare effective date

PART A: MONTH: _____ YEAR: _____

PART B: MONTH: _____ YEAR: _____

PART D: MONTH: _____ YEAR: _____

IMPORTANT

You and your eligible dependents **must be enrolled with the same Plan**. For example, if you have Medicare and elected Kaiser's Senior Advantage (box **C** below) and your spouse is Non-Medicare, she must elect Kaiser Permanente (box **A** on front page). Your spouse cannot elect the Laborers Direct Payment Plan (box **B**).

A copy of your Medicare Card (with Parts A & B) is required. If both you and your Spouse are eligible for Medicare, **YOU MUST ENROLL IN THE SAME PLAN** by checking box **C** or **D** below.

☐ C **Kaiser Permanente Senior Advantage Plan – Group 603307**

If you elect Kaiser Senior Advantage Plan, you must also complete their application form for each person enrolling in Kaiser Senior Advantage Plan and mail all the applications to the Trust Fund Office – do NOT mail the applications to Kaiser Permanente.

☐ D **Laborers Direct Payment Plan**

I apply for health plan membership. I certify under penalty of perjury, under the laws of California that the information given in this form is true, correct, and complete to the best of my knowledge.

DATE:_____RETIREE'S SIGNATURE:_____

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.

_____ DATE

_____ SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN

FUND OFFICE USE ONLY (Please do not write in this space)

☐ NEW RETIREE
☐ OPEN ENROLLMENT
☐ NEW DEPENDENT
☐ DELETE DEPENDENT

☐ COBRA

DATE OF QUALIFYING EVENT

_____

REMARKS:

_____

_____

DATE:_____BY:_____