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.:

ACTIVE PLAN & SPECIAL PLAN APPLICATION FORM

PARTICIPANT INFORMATION (Please print or type in black ink only)

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST				
RESIDENCE ADDRESS (not Post Office Box)	CITY		STATE ZIP CODE		
TELEPHONE NO. ( )	LOCAL UNION	DATE OF BIRTH MONTH	DAY	YEAR	GENDER ☐ MALE ☐ FEMALE / MARITAL STATUS ☐ SINGLE ☐ MARRIED

BENEFIT HEALTH PLAN OPTIONS (You & your Dependents must be enrolled in the **same** Benefit Health Plan.)

☐ **LABORERS DIRECT PAYMENT PLAN**

☐ **KAISER PERMANENTE** IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #:_____

DEPENDENT INFORMATION (List all eligible dependents; use reverse side if you need more space)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM PARTICIPANT)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #
☐ SPOUSE ☐ DOMESTIC PARTNER	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				
CHILD	☐ MALE ☐ FEMALE				

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:_____ PARTICIPANT'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 PARTICIPANT ☐ OPEN ENROLLMENT ☐ NEW DEPENDENT
☐ COBRA - DATE OF QUALIFYING EVENT_____

REMARKS:

DATE:_____BY:_____