LABORERS FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA
5672 Stonebridge Drive, Suite 100, Pleasanton, CA 94588
Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@norcalaborers.org
Website: http://www.lfao.org

FUND OFFICE USE ONLY (610)
EFF. DATE:
HCID: **LA**
ELIGIBILITY CODE/GROUP NO.:

ACTIVE PLANS VISION ENROLLMENT FORM

EMPLOYEE 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

VISION PLAN OPTIONS

IMPORTANT: You and your Dependents must be enrolled in the same Vision Plan. Check only one box. In the absence of an election, you and your Dependents will be automatically enrolled in Blue View Vision if you have elected the Direct Payment Plan, or will be enrolled in Kaiser Vision Essentials if you have elected the Kaiser Plan.

☐ **Blue View Vision.** You may elect this option if you are enrolled in the Direct Payment Plan OR the Kaiser Plan. You may use any provider for vision services in the Anthem Blue View Vision network.

☐ **Kaiser Vision Essentials**. You may elect this option **only** if you are enrolled in the Kaiser Plan. You must obtain vision services from Kaiser only. If at any time you change your medical plan election to the Direct Payment Plan, your vision election (should you choose Kaiser Vision Essentials) will be automatically changed to Blue View Vision.

DEPENDENT INFORMATION (List all eligible dependents to be enrolled. Use back page if more space needed.)

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	DEPENDENT RELATIONSHIP
1.		SPOUSE
2.		☐ SON ☐ DAUGHTER
3.		☐ SON ☐ DAUGHTER
4.		☐ SON ☐ DAUGHTER
5.		☐ SON ☐ DAUGHTER

I understand that once I have selected a Plan, I cannot change to another Plan until the next Open Enrollment. I agree to be bound by the benefits, deductions, co-payments, exclusions and other terms of the Plan group agreement. **Your application will not be accepted without your signature below. Please return this Enrollment Form to the Fund Office.**

Important: If you enroll in Kaiser Vision Essentials, any dispute that may arise between you and Kaiser Vision Essentials will be subject to binding arbitration.

Date:_____ Employee's Signature:_____

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

☐ NEW EMPLOYEE ☐ OPEN ENROLLMENT ☐ COBRA - DATE OF QUALIFYING EVENT_____	REMARKS: DATE:_____ BY:_____

Revised 10/5/2021