



**CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**
 220 Campus Lane, Fairfield, CA 94534-1499
 Telephone: (707) 864-3300 or Toll-Free at 1-888-245-5005
 E-Mail Address: customerservice@norcalcementmasons.org
 Website: http://www.norcalcementmasons.org

FUND OFFICE USE ONLY (10)
EFF. DATE:
HCID: CM
ELIGIBILITY CODE/GROUP NO.:

ACTIVE PLAN APPLICATION 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	

BENEFIT HEALTH PLAN OPTIONS

IMPORTANT: You & your Dependents must be enrolled in the same Benefit Health Plan. Check only one box.

CEMENT MASONS DIRECT PAYMENT PLAN **KAISER PERMANENTE** IF NOW OR PREVIOUSLY A KAISER MEMBER, ENTER MEDICAL RECORD #: _____

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

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #	DEPENDENT RELATIONSHIP	FUND OFFICE USE ONLY
1.				SPOUSE	
2.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
3.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
4.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
5.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
6.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT

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.

I UNDERSTAND THAT EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO THE MEDICARE APPEALS PROCEDURE, OR BENEFIT-RELATED DISPUTES IN COMPLIANCE WITH ERISA, ANY CLAIM THAT I, MY HEIRS, OR OTHER CLAIMANTS ASSOCIATED WITH ME, ASSERT FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATING TO MALPRACTICE, 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 A LAWSUIT OR COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. I UNDERSTAND THAT THE FULL ARBITRATION PROVISION IS CONTAINED IN THE EVIDENCE OF COVERAGE (EOC). I AGREE TO GIVE UP MY RIGHT TO A JURY TRIAL AND ACCEPT THE USE OF BINDING ARBITRATION. Your application will not be accepted without your signature below.

Date: _____ Employee's Signature: _____

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

<input type="checkbox"/> NEW MEMBER <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> COBRA - DATE OF QUALIFYING EVENT _____	REMARKS: DATE: _____ BY: _____
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