



**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.:

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 NO. ()	LOCAL UNION	DATE OF BIRTH	GENDER
		MONTH DAY YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
			<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**
 YOUR MEDICAL RECORD #: _____

MEDICARE INFORMATION

If you or your spouse has Medicare, write the effective date below and submit a copy of the Medicare Card:

YOUR Medicare effective date **Your SPOUSE** Medicare effective date

PART A: MONTH: _____ YEAR: _____ **PART A:** MONTH: _____ YEAR: _____

PART B: MONTH: _____ YEAR: _____ **PART B:** MONTH: _____ YEAR: _____

PART D: MONTH: _____ YEAR: _____ **PART D:** MONTH: _____ YEAR: _____

A Kaiser Permanente Senior Advantage Enrollment Form must be completed if you or your spouse has Medicare coverage and you elect Kaiser Permanente Senior Advantage.

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

NAME. FIRST & MIDDLE INITIAL (& LAST NAME IF DIFFERENT FROM RETIREE)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	KAISER MEDICAL RECORD #	DEPENDENT RELATIONSHIP
1.				SPOUSE
2.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

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: _____ Retiree'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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