CEMENT MASONS HEALTH AND WELFARE TRUST
FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd, Suite 100
Dublin, CA 94568
Telephone: (707) 864-3300 or (888) 245-5005
Email Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY (536)	
EFF. DATE:	
HCID: HA	
ELIGIBILITY CODE/GROUP NO.:	

ACTIVE PLAN APPLICATION FORM

PARTICIPANT INFORMATION (Please print clearly using ink pen)

LAST NAME	FIRST NAME	MIDDLE

HOME ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	SOCIAL SECURITY NO.	MARITAL STATUS: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced Eff.DATE (if not single):	GENDER: ☐ Male ☐ Female

TELEPHONE NO.	MOBILE PHONE NO.	EMAIL ADDRESS

LOCAL UNION	EMPLOYER NAME	HIRE DATE

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

☐ DIRECT PAYMENT PLAN (ANTHEM)	☐ KAISER PERMANENTE IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #_____

DEPENDENT INFORMATION (List all eligible dependents; use a blank page if you need more space)

LAST NAME FIRST M.I	D.O.B	S.S.N.	GENDER	RELATIONSHIP	KAISER MEDICAL RECORD # (IF APPLICABLE)
			☐ MALE ☐ FEMALE	☐ SPOUSE ☐ DOMESTIC PARTNER	
			☐ MALE ☐ FEMALE	☐ CHILD ☐ STEPCHILD ☐ OTHER*	
			☐ MALE ☐ FEMALE	☐ CHILD ☐ STEPCHILD ☐ OTHER*	
			☐ MALE ☐ FEMALE	☐ CHILD ☐ STEPCHILD ☐ OTHER*	
			☐ MALE ☐ FEMALE	☐ CHILD ☐ STEPCHILD ☐ OTHER*	
			☐ MALE ☐ FEMALE	☐ CHILD ☐ STEPCHILD ☐ OTHER*	

Does anyone listed on this form have health insurance through another source? ☐ Yes ☐ No

If Yes, name of other coverage and persons covered: _____

_____

***Please attach copy of insurance card. A dual coverage questionnaire may be sent for additional information.

COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF THE MEDICARE CARD IF YOU OR A DEPENDENT(S) ARE ENROLLED IN MEDICARE

PLEASE LIST THE INDIVIDUAL(S) RECEIVING MEDICARE	RECEIVING PART A? ☐ YES ☐ NO	RECEIVING PART B? ☐ YES ☐ NO
NAME:_____ NAME:_____	EFFECTIVE DATE A: _____/_____/_____	EFFECTIVE DATE B: _____/_____/_____

IS ANYONE LISTED RECEIVING KIDNEY DIALYSIS OR A TRANSPLANT

PLEASE LIST THE INDIVIDUAL(S) RECEIVING DIALYSIS OR TRANSPLANT	RECEIVED KIDNEY TRANSPLANT	RECEIVING DIALYSIS
NAME:_____ NAME:_____	☐ Yes ☐ No DATE OF TRANSPLANT: _____/_____/____	☐ Yes ☐ No DATE OF FIRST TREATMENT: _____/_____/____

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, Inc., California 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.

Note: If you do not wish to accept the arbitration agreement above you must make a new Health Plan selection.

DATE:_____ PARTICIPANT'S SIGNATURE:_____

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: