CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
4160 Dublin Blvd Suite 100
Dublin, CA 30084
Telephone: (707) 864-3300 or (888) 245-5005
E-Mail Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY (640)
EFF. DATE:
HCID: **HA**
ELIGIBILITY CODE/GROUP NO.:

RETIREE HEALTH AND WELFARE APPLICATION FORM

RETIREE INFORMATION (Please print clearly using ink pen)

Last Name:	First Name:	Middle:

Social Security#	Date of Birth: Month Day Year	Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married

Residence Address (not a P.O.Box): Street City State ZIP Code	Phone Number: ( )	Local Union:

Are you enrolling as a Beneficiary of a deceased retiree? ☐ No ☐ Yes
(If Yes, provide the deceased retiree's Social Security Number):

DEPENDENT INFORMATION (List all eligible dependents to be enrolled)

Full Legal Name (Last, First, M.I.)	Date of Birth (MO/DAY/YR)	Social Security #	Gender	Relation	Kaiser Medical Record# **If Applicable
			☐ Male ☐ Female	☐ Spouse ☐ Child	
			☐ Male ☐ Female	☐ Child ☐ Other	
			☐ Male ☐ Female	☐ Child ☐ Other	
			☐ Male ☐ Female	☐ Child ☐ Other	

***If you have additional dependents, please request an additional application or add on a piece of paper.**
****Kaiser Medical Record Number –** If you selected to enroll in Kaiser and you or any of your dependents previously had Kaiser we need the Medical Record number for each participant. **Retiree(s) Kaiser Medical Record:** _____

Do you or any of your dependents have other insurance? ☐ No ☐ Yes
(if yes, please list each dependent and a provide copy of the insurance card) _____

_____

_____

Is Anyone Listed on this Application Receiving Kidney Dialysis or had a Transplant? ☐ **No** ☐ **Yes** (if yes, complete below)

Name:	**Receiving Dialysis**	**Received Kidney Transplant**
	First Date of Treatment:	Date of Transplant:
Name:	**Receiving Dialysis**	**Received Kidney Transplant**
	First Date of Treatment:	Date of Transplant:

Please read the following important notice before making an election.

The Plan's term "**Eligible for Medicare**" means an individual who is **qualified to enroll** in both Federal Medicare Parts A and B **whether or not** the individual has actually enrolled for Medicare.

You are Eligible for Medicare Parts A and B if you are:

- **age 65 or older**,
- under 65 and receiving Social Security Disability for at lease 24 months or
- have End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)

If you are an individual "Eligible for Medicare" who did not enroll in both Medicare Parts A and B:

(1) You cannot elect Kaiser as they require the individual to be enrolled in both Medicare Parts A and B.
(2) If you elect the Direct Payment Plan , the Plan will charge the Medicare Premium Rate and payable benefits will be **estimated** as if you were enrolled in Medicare Parts A and B.

*****After you file this application, it is your obligation to notify the Fund Office immediately of any changes to your Medicare enrollment status.**

Does Anyone Listed on this Application have Medicare Parts A, B or D ☐ No ☐ Yes (if yes, complete below)

***Please attach a copy of each Medicare card.**

Name:	**Part A Only**	**Part A & B**	**Part D**
	Effective Date:	Effective Date:	Effective Date:
Name:	**Part A Only**	**Part A & B**	**Part D**
	Effective Date:	Effective Date:	Effective Date:

Medical Plan Options (Check only one box) *** You and your dependents must be enrolled with the same Plan.**

PLAN OPTIONS FOR INDIVIDUALS WHO ARE NOT ELIGIBLE FOR MEDICARE (Check only one box)

☐ **A. Kaiser Permanente**

☐ **B. Cement Masons Direct Payment Plan**

PLAN OPTIONS FOR MEDICARE-ELIGIBLE INDIVIDUALS (Check only one box)

☐ **A. Kaiser Permanente Senior Advantage Plan****

☐ **B. Anthem Medicare Advantage MAPD**

**(You must complete a Kaiser application for each enrollee)

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 **SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN**

Optional Coverage

IMPORTANT:

The dental and vision plan options are being offered at an <u>additional cost to you,</u> please contact Trust Fund Office for current pricing.

If you decline enrollment in the optional dental or vision plan or if you cancel after 36 months**, **you will not be able to re-enroll for benefits.

Dental Plan Options (Check only one box) * You and your dependents must be enrolled with the same Plan.

If you enroll in DeltaCare USA or UnitedHealthcare Dental, any dispute that may arise between you and the Dental Plan will be subject to binding arbitration.

☐ **Delta Dental.** You may seek dental care from any dentist but, your out-of-pocket expense is lower if you use a participating Delta Dental dentist.

☐ **DeltaCare USA.** You must select a Dental Office from Delta Care Participating Dental Offices Directory:

Name of Dental Office: Facility No.:

☐ **UnitedHealthcare Dental.** You must select a dentist or dental group from UnitedHealthcare Dental Provider Directory:

Name of Dentist: Dentist No.:

☐ **I Decline Dental Coverage:** By checking this box <u>you will not be able to enroll for benefits in the future.</u>

Vision Plan Options (Check only one box) * You and your dependents must be enrolled with the same Plan.

If you choose to enroll in the optional VSP, you must keep it for a minimum of 36-months. If you cancel the VSP **before** 36-months, **<u>you will also be cancelling your hospital-medical plan (and optional dental plan if you have enrolled for that coverage)</u>**. If you are unsure whether you have met the 36-month provision, call the Trust Fund Office for assistance.

☐ **Yes, I want to enroll in Vision Coverage**

☐ **I Decline Vision Coverage:** By checking this box <u>you will not be able to enroll for benefits in the future.</u>

Your application will not be processed without your signature below.

Please return this Enrollment Form to the Fund Office.

- I understand that once I have selected a Dental 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.
- I understand that if I decline either dental or vision coverage, I can not enroll at a later time.
- I have read and understand the requirements, terms, conditions, limitations, provisions, and other information discussed in the enrollment materials.
- I understand that my Health & Welfare premium will be deducted monthly from my Pension benefits.
- I declare that the statements contained in this enrollment form are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted.

SIGNATURE: _____ **DATE:** _____