NORTHERN CALIFORNIA UFCW WHOLESALE HEALTH & WELFARE FUND

C/O UFCW & EMPLOYERS TRUST, LLC
MAILING ADDRESS: P.O. BOX 4100 • CONCORD, CA 94524-4100
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☐ **NEW MEMBER** OR **CHANGE OF:** ☐ **NAME** ☐ **MARITAL STATUS** ☐ **PLAN SELECTION** ☐ **ADDRESS** ☐ **DEPENDENTS**

ENROLLMENT CHANGE FORM

LAST NAME	FIRST NAME	INT.	SOCIAL SECURITY NUMBER		
MAILING ADDRESS (STREET OR P. O. BOX)			SEX	DATE OF BIRTH	UNION LOCAL
MAILING ADDRESS LINE 2			E-MAIL ADDRESS		
CITY	STATE	ZIP	TELEPHONE NUMBER ( )		
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED	DATE OF MARRIAGE/DIVORCE	EMPLOYER NAME AND ADDRESS (CITY ONLY)			DATE OF HIRE

MEDICAL SELECTION – CHOOSE ONE

☐ KAISER PERMANENTE - (HMO PLAN) GROUP

☐ BLUE SHIELD OF CALIFORNIA - (HMO PLAN)

MEDICAL SALINAS RESIDENTS ONLY:

☐ UNITED HEALTHCARE – (PPO PLAN)

DENTAL SELECTION – CHOOSE ONE

☐ DELTA DENTAL (#2455)
☐ DELTACARE (PMI) (05145-001)
☐ NEWPORT (BRIGHTNOW) (#NP3082)
☐ UHC DENTAL (PACIFIC UNION) (#NP3082)

FAMILY DATA

RELATION*	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY #	Receiving Medicare Part A or B	Kidney Transplant or Dialysis
Participant						❑ YES ❑ NO	❑ YES ❑ NO
Spouse						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO

NOTE: To add or change your dependents, the following documentation may be required: Copies of marriage license or divorce papers; birth certificates for dependent children; Legal guardianship or court adoption papers for adopted or court appointed dependents.

ADDITIONAL INSURANCE INFORMATION

Please list any dependent with an address different than the member's address:

Dependent:_____ **Address:**_____ **City**_____ **State**_____ **Zip**_____

Dependent:_____ **Address:**_____ **City**_____ **State**_____ **Zip**_____

Please list ANY dependent who is entitled to benefits from another group health care, insurance, or pre-paid medical plan:

Dependent:_____ **Insurance Co.** _____ **Policy No.** _____

Dependent:_____ **Insurance Co.** _____ **Policy No.** _____

**** YOUR SIGNATURE IS REQUIRED BELOW ****

Important Note: Kaiser and United Healthcare Participants must also sign the arbitration agreement on the reverse side.

Signature: _____ **Date:** _____

DEPENDENT ELIGIBILITY AND ENROLLMENT

If you qualify for benefits, the following dependents may be covered:

- Your lawful spouse
- Unmarried children who are less than 26 years of age. The definition of unmarried children are those declared by you as dependents for federal income tax purposes and include your:
  - Natural children
  - Stepchildren
  - Legally adopted children from the time they are placed in your custody
  - Children for whom adoption proceedings have been started
  - Children for whom you have been legally appointed guardian
  - Any child required to be recognized under a qualified medical child support order
- Disabled dependent children over age 26 and incapable of self-supporting employment because of mental retardation or physical handicap will have eligibility extended.
- Eligibility for all persons listed above shall be subject to all provisions and limitations of the trust agreement and plan document as well as to any rules or regulations adopted by the Board of Trustees.

UNITED HEALTHCARE HEALTH PLAN MEMBERS ONLY

READ CAREFULLY: By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as valid as the original.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare of California and Nevada, UnitedHealthcare or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Signature (Required):	Date (Required)

KAISER PERMANENTE MEMBERS ONLY

Kaiser Foundation Health Plan, Inc., 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*.

Signature (Required):	Date (Required):

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

BENEFICIARY DESIGNATION FORM

This Enrollment Form provides you with the opportunity to name a beneficiary for life and AD&D Benefits available under the Plan. Please enter the full name and address and relationship to you. The % allocation, the date of birth and Social Security number should be shown for each beneficiary.

P/C	Full Name and Address	%	Relationship	Date of Birth	Social Security No.

YOUR SIGNATURE CONFIRMS THE BENEFICIARY DESIGNATION SHOWN ABOVE

Signature:_____ **Date:** _____