NORTHERN CALIFORNIA UFCW WHOLESALE HEALTH & WELFARE FUND

C/O UFCW & EMPLOYERS TRUST, LLC
MAILING ADDRESS: P.O. BOX 4100 • CONCORD, CA 94524-4100
PHONE: (800) 552-2400 • FAX: (925) 746-7549

RETIREE ENROLLMENT FORM

COMPLETE ALL INFORMATION – PLEASE PRINT IN BLACK OR BLUE PERMANENT INK

PARTICIPANT DATA

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 ☐ DOMESTIC PARTNER	DATE OF MARRIAGE/DIVORCE		ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B? ☐ YES – EFFECTIVE DATE _____ ☐ NO		

MEDICAL SELECTION-NON-MEDICARE – CHOOSE ONE

☐ KAISER (HMO DEDUCT) ☐ BLUE SHIELD (HMO DEDUCT)

MEDICAL SELECTION MEDICARE ELIGIBLE – CHOOSE ONE

☐ BLUE SHIELD MEDICARE SUPPLEMENT	☐ KAISER – SENIOR ADVANTAGE	☐ UNITED HEALTH CARE SENIOR SUPPLEMENT ☐ HEALTH NET – SENIORITY PLUS ☐ HEALTH NET MEDICARE SUPPLEMENT

DENTAL SELECTION - (CHOOSE ONE ONLY IF YOUR BENEFITS INCLUDE DENTAL COVERAGE)

☐ DELTA PPO DENTAL GRP# 2455-0002 ☐ DELTA CARE (PMI) GRP #05145-001
☐ NEWPORT DENTAL (BRIGHT NOW!) GRP# NP3083 ☐ UHC DENTAL HMO GRP #

FAMILY DATA

RELATION*	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY #	HMO PCP & PPG # OF KAISER MEDICAL RECORD NO.
Participant						
Spouse/Domestic Partner						
Dependent*						
Dependent*						
Dependent*						

***Relation – Spouse, Son, Daughter, Step-son, Step-daughter, Other – See dependent on reverse side**

Important Notice: I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the Health Maintenance Organization (HMO) service agreement or preferred provider plan regulations, whichever applies. I understand that the service agreement provides that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me, believe that some conduct in, or arising from my relationship with the HMO, HMO hospitals, or the HMO medical group, as a member or as a patient, has cause any harm, must be submitted to binding arbitration instead of court trial.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities. Health Net Entities may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for overage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the web site at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 30 months from the date of my signature below. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract of Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION AGREEMENT: Subject to their terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the applicant understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding construction, interpretations, performance or breach of the Health Net Plan Contact or Insurance Policy, or regarding other matters relating to or arising out of my Health Net members, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu or a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutionals right to have their disputes decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to biding arbitration and binding arbitration. A more detailed arbitration provisions is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

DATE:_____ SIGNATURE: _____

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

Northern California UFCW Wholesale Health And Welfare Fund
INSTRUCTIONS: (Please read carefully before completing the "Enrollment Form")

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health & Welfare coverage under one of the Fund's Plans. Be sure to complete all of the information requested on the Enrollment form. Under the terms of your coverage, you may make an election of the Medical and Dental Plan. Be sure to complete the box marked "CHOICE OF PLANS".

Please read your Summary Plan Description for descriptions of the various plans. Once you enroll in a medical and dental plan, you may not change to another option until you have been in your current plan for at least 12 months.

TO ADD OR CHANGE YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION MAY BE REQUIRED.

- COPIES OR CERTIFIED MARRIAGE CERTIFICATE OR DIVORCE PAPERS
- COPIES OF CERTIFIFED BIRTH CERTIFICATES FOR DEPENDENT CHILDREN
- FOSTER & ADOPTED CHILDREN: LEGAL GUARDIANSHIP OR COURT ADOPTION PAPERS

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.

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.*

The Enrollment Form requires that you name a beneficiary to your Death and Accidental Death & Dismemberment Benefits under the Fund. Be sure to complete it and be specific as to whom you are naming – give full name with Jr., Sr. etc. to avoid confusion with anyone else.

BENEFICIARY OF DEATH BENEFIT

BENEFICIARY'S FULL NAME & ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #

YOU MUST SIGN BELOW TO AUTHORIZE THE BENEFICARY DESIGNATIONS

Signature:_____ **Date:** _____