LABORERS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1498
Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@norcalaborers.org
Website: http://www.norcalaborers.org

FUND OFFICE USE ONLY (640)
EFF. DATE:
HCID: **LA**
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 NUMBER	LOCAL UNION	DATE OF BIRTH			SEX	MARITAL STATUS
		MONTH	DAY	YEAR		
( )					☐ MALE ☐ FEMALE	☐ SINGLE ☐ MARRIED

ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED RETIREE? ☐ NO

☐ YES: PROVIDE THE DECEASED RETIREE'S SOCIAL SECURITY NUMBER:

DEPENDENT INFORMATION (List all eligible dependents to be enrolled)

RELATIONSHIP	NAME OF DEPENDENT write first and middle initial (and last name if different from your last name)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	**Kaiser** Medical Record Number (see ** below)
SPOUSE				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				

** - If you selected the ***Kaiser Permanente*** or the ***Kaiser Permanente Senior Advantage Plan*** and any of your dependents listed above is currently or formerly a Kaiser Permanente member, write the Medical Record Number, if known, for each dependent and write **YOUR** Kaiser Medical Record Number here ☞ _____.

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER INSURANCE? ☐ NO

☐ YES: PROVIDE NAME OF THE INSURANCE COMPANY:

PLAN OPTIONS FOR PARTICIPANTS WHO ARE NOT ELIGIBLE FOR MEDICARE Check only one box

☐ A **Kaiser Permanente – Group 603307**

☐ B **Laborers Direct Payment Plan**

PLAN OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS Check only one box

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

(1) you cannot elect Kaiser Senior Advantage below as they require the individual to be enrolled in both Parts A and B.
(2) if you elect the Laborers Direct Payment Plan, the Plan will charge you the Medicare premium rate whether or not you enrolled in Medicare Part B, and, will **estimate** the benefits payable under Medicare when your claims are paid.

After you file this application, it is your obligation to notify the Fund Office immediately of any changes to your Medicare enrollment status. Please answer the following questions and make your Plan election below:

YOUR Medicare effective date
PART A: MONTH: _____ YEAR: _____
PART B: MONTH: _____ YEAR: _____
PART D: MONTH: _____ YEAR: _____

Your SPOUSE Medicare effective date
PART A: MONTH: _____ YEAR: _____
PART B: MONTH: _____ YEAR: _____
PART D: MONTH: _____ YEAR: _____

IMPORTANT

You and your eligible dependents **must be enrolled with the same Plan**. For example, if you have Medicare and elected Kaiser Permanente Senior Advantage (box **C** below) and your spouse is Non-Medicare, she must elect Kaiser Permanente (box **A** on front page). Your spouse cannot elect the Laborers Direct Payment Plan (box **B**).

A copy of your Medicare Card (with Parts A & B) is required. If both you and your Spouse are eligible for Medicare and you want to enroll in the same Plan, check box **C** or **D** below.

☐ C **Kaiser Permanente Senior Advantage – Group 603307**
If you check box C, you must also complete a Kaiser Senior Advantage application form for each person wishing to enroll in the Senior Advantage Plan.

☐ D **Laborers Direct Payment Plan**

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)

☐ NEW RETIREE
☐ OPEN ENROLLMENT
☐ ADD DEPENDENT
☐ DELETE DEPENDENT

☐ COBRA
DATE OF QUALIFYING EVENT
_____

REMARKS:
_____
_____
DATE:_____ BY:_____