HAWAII HEALTH & WELFARE TRUST FUND FOR OPERATING ENGINEERS

1600 Harbor Bay Parkway, Suite 200 ✶ Alameda, California 94502-3035
1-800-251-5014 ✶ FAX 510-863-8373

ACTIVE ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ NEW MEMBER CHANGE OF: ☐ NAME ☐ ADDRESS ☐ PLAN ☐ MARITAL STATUS ☐ DEPENDENTS

PARTICIPANT DATA - EMPLOYEE INFORMATION

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	GENDER (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	TELEPHONE NUMBER ( )

EMAIL ADDRESS (REQUIRED)	CELL PHONE NUMBER (REQUIRED) ( )

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	DATE OF MOST RECENT MARRIAGE/DIVORCE	EMPLOYER	DATE OF HIRE

CHOICE OF PLANS

MEDICAL SELECTION – CHOOSE ONE:

☐ HMSA GRP #879-3

☐ KAISER PERMANENTE HMO GRP #6592

IF APPLICABLE, REGARDLESS OF CHOICE OF MEDICAL PLAN, ALL ELIGIBLE MEMBERS AND THEIR ELIGIBLE DEPENDENTS HAVE:

- DENTAL COVERAGE THROUGH HAWAII DENTAL SERVICE – HDS 800-232-2533 GRP# 0067-0001
- VISION COVERAGE THROUGH VISION SERVICE PLAN – VSP 800-877-7195 GRP# 00873005-0006-002

HMSA PLAN PARTICIPANTS' PRESCRIPTION COVERAGE IS THROUGH HMSA (888-948-6109)

KAISER PLAN PARTICIPANTS' PRESCRIPTION COVERAGE IS THROUGH KAISER 800-966-5955 OR, OAHU 432-5955

FOR HMSA USE ONLY
SUB ID NO. _____
EFF DATE _____
GRP# _____
CONT _____ PKG _____
DEPT NO. _____
APP RCV DATE _____
PROC DATE _____
TRX _____

Personal & Dependent Data

PROVIDE THE SOCIAL SECURITY NUMBER OF EACH DEPENDENT YOU ENROLL.
FEDERAL REGULATIONS REQUIRE HEALTH PLANS TO REPORT THE NAMES AND SOCIAL SECURITY NUMBERS OF EVERY COVERED INDIVIDUAL TO THE IRS.

BEFORE ALLOWING A DEPENDENT TO BE ADDED TO THE PLAN, THE TRUST OFFICE REQUIRES ALL DOCUMENTATION SUCH AS MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, DOMESTIC PARTNER CERTIFICATE, DIVORCE, OR REMARRIAGE DOCUMENTS.

Relation*	Last Name	First Name	Gender	Date of Birth	Social Security Number	Receiving Medicare Part A or B	Kidney Transplant or Dialysis
Self						Yes ☐ No ☐	Yes ☐ No ☐
Spouse						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐
Dependent Type						Yes ☐ No ☐	Yes ☐ No ☐

*Relation –Son, Daughter, Stepson, Stepdaughter, etc. See the General Eligibility Rules on this form for definition of "ELIGIBLE DEPENDENTS"
**If you are the subscriber of an HMSA Individual plan (Conversion Plan, Individual Business Plan, Plan 6, Student Plan 19, or HPH Individual Conversion Plan) now, do you wish to cancel that membership if this application is accepted? ☐ Yes ☐ No

Complete the section below and enclose a copy of the Medicare card if you or a dependent are enrolled in Medicare

List the individual receiving Medicare		
Name:_____	Receiving Part A? Yes ☐ No ☐	Effective Date A: ____/____/____
	Receiving Part B? Yes ☐ No ☐	Effective Date B: ____/____/____

List the individual receiving Medicare Name:_____	Receiving Part A? Yes ☐ No ☐ Receiving Part B? Yes ☐ No ☐	Effective Date A: ____/____/____ Effective Date B: ____/____/____

Additional Insurance Information

List ANY dependent with an address different than the member's address:

Dependent:	Address:	City	State	ZIP
Dependent:	Address:	City	State	ZIP

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

Dependent:	Insurance Company	Policy Number
Dependent:	Insurance Company	Policy Number

Complete this section if you checked yes to kidney transplant or receiving dialysis

List the individual receiving Dialysis or Transplant	Received Kidney Transplant Yes ☐ No ☐ Receiving Dialysis Yes ☐ No ☐	Date of Transplant:: ____/____/____ Date of first treatment: ____/____/____

KAISER PERMANENTE HEALTH PLAN ARBITRATION AGREEMENT:

Your application cannot be processed without your signature. Read the reverse side before signing.

I apply for health plan membership for the persons listed and agree that we shall abide by the group medical and hospital service agreement, benefit schedule, riders, and contract face sheet, including provisions which require that:

1. Except for certain situations outlined in the group medical and hospital service agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, see your group medical and hospital service agreement.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the member receives) if the care is for harm caused or alleged to be caused by a third party.
3. I had an opportunity to read the privacy information on the back of this form.
4. I certify that I am at least 18 years of age and have the legal authority to contract for medical insurance for the person(s) listed on the enrollment form.

KAISER PERMANENTE IMPORTANT ADDRESS INFORMATION:

Subscriber and eligible dependents may enroll if living in the Hawaii service area of Oahu, Maui, and Hawaii (except for ZIP codes 96718, 96772, and 96777) at the time of enrollment. After enrollment, members must continue to live in the Hawaii service area in order to remain a member.

HMSA CONDITIONS OF ENROLLMENT:

If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal care physician. I further understand that as an HMSA member, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the health/dental plan; and (b) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan. I also agree that HMSA shall set the date on which my health/dental plan coverage shall begin.

KAISER PERMANENTE PRIVACY INFORMATION:

Your privacy is important to us. Our physicians and employees are required to keep your protected health information (PHI) confidential whether it is.oral, written, or electronically transmitted. We have policies, procedures, and other safeguards in place to help protect your PHI from improper use and disclosure in all settings, as required by state and federal laws.

We will release your PHI when you give us written authorization to do so, when the law requires us to disclose information, or under certain circumstances when the law permits us to use or disclose information without your permission. For example, in the course of providing treatment, our health care professionals may use and disclose your PHI in order to provide and coordinate your care, without obtaining your authorization.

Your PHI may also be used without your authorization to determine who is responsible to pay for medical care and for other health care operations purposes, such as quality assessment and improvement, customer service and compliance programs. If you are enrolled in Kaiser Permanente through your employer or employee organization, we may be allowed under the law to disclose to them certain PHI, for example, regarding health plan eligibility or payment, or regarding a workers' compensation claim. Sometimes we contract with others (business associates) to perform services for us and in those cases, our business associates must agree to safeguard any PHI they receive.

Our privacy policies and procedures include information on your right to see, correct or update, and receive copies of your PHI. You may also ask us for a list of our disclosures of your PHI that we are required to track under the law.

For a more complete explanation of our privacy policies, please request a copy of our "Notice of Privacy Practices" which is on our Web site, in our medical offices, or by calling our Customer Service Center. If you have questions or concerns about our privacy practices, please contact our Customer Service Center at 432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands).

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 Plan. Be sure to complete the box marked "CHOICE OF PLANS".

GENERAL ELIGIBILITY RULES

YOUR DEPENDENTS, AS DEFINED BELOW, ARE ALSO ELIGIBLE TO RECEIVE BENEFITS.
Your eligible family members are:

- Your lawful spouse provided you are not divorced.
- If you divorce, your former spouse is no longer an eligible family member on the date of the final divorce decree. Notify the Trust Office immediately in the event of a divorce.
- Your dependents up to age 26. For purposes of this Plan, your dependents may include:
- your natural children,
- your legally adopted children (from the time they are placed for adoption),
- your stepchildren, or

  In accordance with ERISA Section 609(a)(2)(A), the Plan will provide coverage for a Dependent child of an Employee if required by a Qualified Medical Child Support Order.

- Your children – regardless of age – who were prevented from earning a living because of mental or physical handicap (providing the disabled children were handicapped and eligible as Dependents at the time they reached the limiting age), and are primarily dependent upon the Employee for support. Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 26, and periodically thereafter. They are not eligible for life insurance benefits.
- Any change in plans will be effective the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form (per the Summary Plan Description).
- When you enroll in a plan option you must remain in the plan for at least 12 months. An exception will be made only if you elected an HMO and you move out of the HMO service area or it ceases to be available where you live (or the Board approves a change).

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TRUST OFFICE AT (800) 251-5014 OR (510) 433-4422.

Important: You can be held liable for benefit payments made based on any incorrect information about your dependents, such as failing to notify the Trust Office if there is a divorce. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information.

ELIGIBILITY FOR ALL PERSONS ENROLLED 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.

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT

By signing below, I declare that have read and understood all information on this enrollment form. I declare that all statements made on this enrollment form are complete and true. I understand that material misrepresentations, omissions, concealment of facts or incorrect statements may void my eligibility for coverage. I understand and consent that information obtained on this enrollment form will be provided to health care organizations for the purpose of providing coverage. I understand that coverage will not be provided until this enrollment is accepted and I meet all eligibility requirements.

DATE:_____ **MEMBER SIGNATURE**_____

***Before allowing a dependent to be added to the Plan, the Trust Office requires all documentation such as marriage certificate, birth certificate, domestic partner certificate, divorce, or remarriage documents.**