PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE FUND

1600 Harbor Bay Parkway, Suite 200✶Alameda, California 94502-3035

1-800-251-5014 ✶ Fax 510-863-8373

MEDICARE RETIREE ENROLLMENT FORM

☐ **NEW MEMBER** **OR** **CHANGE OF:** ☐ **NAME** ☐ **MARITAL STATUS** ☐**PLAN** ☐ **ADDRESS** ☐ **DEPENDENTS**

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

PARTICIPANT DATA

LAST NAME	FIRST NAME	M.I.	FULL SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)			GENDER (M/F)	DATE OF BIRTH
CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
EMAIL ADDRESS	FORMER EMPLOYER		DATE OF TERMINATION	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			DATE OF MOST RECENT MARRIAGE/DIVORCE	

CHOICE OF PLANS

MEDICAL SELECTION – CHOOSE ONE:

☐ **COMPREHENSIVE** (1)
☐ **PACIFICARE SECURE HORIZONS** (2)(3)
☐ **KAISER SR ADVANTAGE GRP# 7703** (2)(3)
☐ **HEALTHNET SR PLUS** (2)(3)

NOTES:

(1) THIS FORM SERVES AS YOUR ENROLLMENT FORM FOR THESE PLANS.
(2) YOU MUST COMPLETE A SEPARATE FORM IF YOU SELECT THESE PROVIDERS
(3) YOU MUST BE ENROLLED IN BOTH MEDICARE PARTS A & B – SEND A COPY OF YOUR MEDICARE CARD.

ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B?

☐ YES EFFECTIVE DATE___________
☐ NO

DENTAL FOR MY CHILD(REN):

☐ I WISH TO ENROLL MY CHILD(REN) IN THE DENTAL PLAN I AM ENROLLED IN.
☐ I DO NOT WANT TO ENROLL MY CHILD(REN) IN THE DENTAL PLAN. I UNDERSTAND I CANNOT ENROLL THEM AT A LATER DATE.

IF YOU SELECT KAISER AS YOUR MEDICAL PLAN AND WERE PREVIOUSLY COVERED BY KAISER, PROVIDE YOUR KAISER MEDICAL RECORD NUMBER (IF ANY)________________________________

FAMILY 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.

FULL NAME	RELATION*	GENDER (M/F)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	OTHER INSURANCE? (see below)	ADDRESS SAME AS MEMBER? (If no, provide below)
PARTICIPANT					YES ☐ NO ☐	YES ☐ NO ☐
SPOUSE					YES ☐ NO ☐	YES ☐ NO ☐
DEPENDENT CHILD					YES ☐ NO ☐	YES ☐ NO ☐
DEPENDENT CHILD					YES ☐ NO ☐	YES ☐ NO ☐
DEPENDENT CHILD					YES ☐ NO ☐	YES ☐ NO ☐

*Relation – Son Daughter, Stepson, Stepdaughter, Adopted child, etc.

LIST ANY ENROLLEE WHO IS ENTITLED TO BENEFITS FROM ANOTHER GROUP HEALTH CARE, INSURANCE, OR PRE-PAID MEDICAL PLAN:

Dependent: ____________________ Insurance Company ____________________ Policy # ____________
Dependent: ____________________ Insurance Company ____________________ Policy # ____________
Dependent: ____________________ Insurance Company ____________________ Policy # ____________
Dependent: ____________________ Insurance Company ____________________ Policy # ____________

If a dependent child is listed above, I authorize a deduction of $179.00 per child for medical, prescription drug (if applicable), vision care (if applicable) and any additional deduction required for the dental coverage. All provisions of the Pension Deduction Authorization currently on file with the fund for me apply to this authorization. If additional space is required, use the back of this form.

*****THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION. SEE OTHER SIDE*****

PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE FUND

MEDICARE RETIREE ENROLLMENT FORM

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, believed 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 caused any harm, must be submitted to binding arbitration instead of court trial.

I understand that the Pensioned Operating Engineers Health and Welfare Trust Fund has no enforceable right in, or to my Pension Plan benefit payment or portion thereof, except the payments actually received by the Health and Welfare Fund pursuant to this authorization. I also understand that I may revoke this authorization at any time if I notify the Pension Plan, in writing, of my with to terminate the deduction, and that in the event of such termination the Health and Welfare coverage for myself and/or my dependent child(ren) will also terminate and I will not be able to reenroll at a later date.

Kaiser Permanente Health Plan Arbitration Agreement: I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its Health Care Providers, or other associated Parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for Medical or Hospital 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 lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the Evidence of Coverage.

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION

DATE:____________________ SIGNATURE____

CC: MEDICAL CLAIMS ______ CC: DENTAL CLAIMS ______ CC: PENSION ______ CC: HAWAII FBO ______

$2,500 DEATH BENEFIT

A $2,500 lump sum benefit will be paid to your beneficiary in the event of your death from any cause while eligible under the Plan. The benefit may be taxable to your beneficiary. Beneficiaries should consult their tax advisors.

Your beneficiary may be any person or persons you name on your beneficiary form, below. If you do not name a beneficiary, or if the named beneficiary is not living or cannot be found, the benefit will be paid to the surviving person or persons in the following order:

- Spouse or domestic partner
- Natural or adopted children
- Parent
- Brothers and sisters
- Nieces and nephews
- Estate

You may request a change of beneficiary at any time by submitting a new beneficiary form to the Trust Fund office. A change of beneficiary will take effect as of the date you signed the new beneficiary form but will not affect any payment the Trust Fund made before receiving your new beneficiary form.

PRIMARY BENEFICIARY(IES):

Name	Address	SSN	Relationship to Participant	Date of Birth	% Share

CONTINGENT BENEFICIARY(IES)

Except as provided above, in the event that none of the primary beneficiary(ies) survive me, the following named contingent beneficiary(ies) will receive the remaining 60 monthly payments (if any). If I name more than one contingent beneficiary and a contingent beneficiary predeceases me, that deceased contingent beneficiary's share will go proportionately to the other named contingent beneficiary(ies) who survive me.

Name	Address	SSN	Relationship to Participant	Date of Birth	% Share

These designations made by the above-named Participant:

______________________________________ ______________________

Participant Signature Date

Form Valid 1/1/2017