NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

935 Detroit Avenue, Suite 242A, Concord, CA 94518-2501 • Phone 925/356-8921 • Fax 925/356-8938
tfo@ncpttf.com • www.ncpttf.com

KAISER PERMANENTE HMO *SURVIVING DEPENDENT* ENROLLMENT/CHANGE FORM ("FORM")

You must complete numbers 1 through 17 in blue or black ink. Form may be considered invalid if it: (a) is not completed in full or (b) contains any type of alterations (e.g. correction tape, white out, etc.). Invalid Forms will be returned to you for completion prior to processing. Read instructions on reverse side prior to completing this Form.

IMPORTANT NOTE – DO NOT DELAY: Full completion and return of this Form is mandatory for all Participants for enrollment, changes, and upon request by the Trust Fund Office. For any Dependents listed on the Form, legal documentation establishing the Participant's relationship to the Dependent (e.g. certified birth certificate, certified marriage certificate, etc.) needs to be on file with the Trust Fund Office. If you have not already submitted such documentation for any Dependent listed on this Form, you should attach a copy when you submit the completed Form.

SURVIVING DEPENDENT INFORMATION

1. Last Name, include Suffix (if applicable)	2. First Name	3. M.I.	4. Sex	5. Date of Birth	6. Social Security Number
			❑ M ❑ F	/ /	- -

7. Mailing/Residence Address	City	State	Zip Code

8. Marital Status	9. Are you Eligible for Medicare?	10. Surviving Dependent's
❑ Widowed ❑ Married ❑ Never Married ❑ Widowed and Remarried **Applicable Date of Current Marital Status:** _____/_____ Month Year	❑ Yes ❑ No If yes complete the following, and attach a copy of your Medicare Card Part A ❑ Part B ❑ Effective Date(s) _____ / _____ Month Year	**Primary Phone** ( ) - Secondary **Phone** ( ) - **Email Address:** _____

HEALTH PLAN SELECTION

This Selection is for your entire family. Important: The Kaiser Permanente HMO Health Plan option has limitations in their coverage service area. To enroll in the Kaiser Permanente HMO Plan, the Surviving Dependent and all of their eligible Dependent(s) must reside in the Northern California Service Area provided for under the Kaiser Permanente HMO Plan.

11.	
	☒ Kaiser Permanente HMO Plan (Coverage is limited to the Northern California Service Area only)

DEPENDENT CHILD INFORMATION

When completing this Form, ALL Dependents eligible to be enrolled and maintained in the Plan must be listed. Failure to list any/all eligible Dependents on the Form will result in termination of their Health and Welfare coverage. Refer to reverse side for definitions of eligible Dependents.

12. Dependent Child (ONE) (Complete All Sections)	Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
❑ Natural Child ❑ Stepchild ❑ Other - Define:				❑ M ❑ F	/ /	- -
	Address		**City**		**State**	**Zip Code**
	Is this Dependent Disabled? ❑ Yes ❑ No					

13. Dependent Child (TWO) (Complete All Sections)	Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
❑ Natural Child ❑ Stepchild ❑ Other - Define:				❑ M ❑ F	/ /	- -
	Address		**City**		**State**	**Zip Code**
	Is this Dependent Disabled? ❑ Yes ❑ No					

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*.

14. Signature Required for Kaiser Permanente Plan _____ **15. Date** _____

Disputes arising from the 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.

IMPORTANT NOTICE: I apply for Health and Welfare coverage through the Plan for myself and the person(s) listed and agree that we shall abide by the provisions of the Northern California Pipe Trades Trust Funds, Kaiser Permanente, Delta Dental, and Vision Service Plan (VSP).

I understand that I will be liable for any claims incurred and/or premiums paid, including costs and attorneys' fees incurred, that result from inaccurate or false statement(s), enrolling or maintaining enrollment of ineligible Dependent(s), and/or failure to notify the Trust Fund Office within 30 days of any change of information listed on the Form. In addition to the applicable Agreement listed above, I also certify that I have read and understand both sides of the Form, the Enrollment Procedures and the Dependent Eligibility Definitions.

Eligibility for all persons listed on this two sided Form are subject to all provisions and limitations of the Trust Agreement and Plan Document (as amended) as well as to any rules and regulations adopted by the Board of Trustees. Please see your Summary Plan Description for details.

I acknowledge that the information provided on this Form is accurate and I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

16. SIGNATURE OF SURVIVING DEPENDENT REQUIRED _____ **17. DATE** _____

TRUST FUND OFFICE USE ONLY: ☐ Audit ☐ Change ☐ IN / OUT of CA / USA ☐ COBRA ☐ New Surviving Dependent	EFFECTIVE DATE:

ENROLLMENT PROCEDURES

IMPORTANT INFORMATION - Please read prior to completing the Enrollment/Change Form ("Form").

- The Form must be completed to enroll you and your Dependents, if applicable, for Health and Welfare coverage under the Northern California Pipe Trades ("NCPT") Health and Welfare Plan within 30 days from the date you become eligible or you acquire a new Dependent (e.g. marriage, birth, adoption, etc.). You are required to notify the Trust Fund Office by full completion of a new Form within 30 days of a change in life circumstances (e.g. marriage, separation, divorce, Surviving Dependent and/or Dependent Child(ren) change of address, new Dependents, Dependent status changes, etc.).
- Plan rules allow an eligible Surviving Dependent to change their Health Plan selection once in any 12 month period. However, Surviving Dependents must be eligible for Health Plan coverage and remain in the selected plan for the next 12 months, unless the Surviving Dependent moves out of the Plan's service area. If special circumstances exist, a change may be approved.
- Generally, if your fully completed Form and any Plan required documentation are received by the 20th of the month, changes will be effective the first of the month following receipt of the Form. Failure to provide Plan required documentation may cause a delay in processing any changes and/or enrollment. Contact the Trust Fund Office for additional information and/or to confirm your exact effective date(s).
- If you and/or your eligible Dependent(s) incur(red) claims prior to your anticipated effective date, contact the Trust Fund Office immediately. Retroactive coverage may be limited due to the Carriers retroactive limitations/rules.
- It is both the Surviving Dependent's and Dependent Children's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. Failure to notify the Trust Fund Office within 30 days of a Dependent's change in eligibility status may be considered fraud and could result in requests for reimbursement of any overpayments and/or loss of certain extensions of coverage for the ineligible Dependent(s). The Surviving Dependent and ineligible Dependent(s) may also be responsible for attorney's fees or other costs incurred by the Plan as a result of maintaining an ineligible Dependent(s).
- The Plan recommends that you and/or your Dependent(s) enroll in Medicare Parts A and B of the Federal program during the three (3) months before the month in which you and/or your Dependent(s) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. Moreover, if you and/or your Dependent(s) are under age 65 but eligible for Medicare, you and/or your Dependents must also enroll for Parts A and B. Proof of Medicare status is required to maintain your coverage and avoid penalties in premiums. Retirees and/or Dependent(s) who are Medicare eligible but fail to enroll in Medicare Parts A and/or B are subject to an additional monthly premium to help offset the additional costs imposed on the Plan for Medicare eligible individuals who elected not to enroll. The rate of this additional premium is determined by the Board of Trustees and will likely increase in the future.

DEPENDENT CHILDREN ELIGIBILITY DEFINITIONS If you are eligible for Retiree Health and Welfare coverage, the following Dependents may be covered:	**PLAN REQUIRED DOCUMENTS** **FOR ENROLLMENT:**	**FOR TERMINATION:**
CHILDREN THROUGH 25 YEARS OF AGE MAY INCLUDE THE DECEASED PARTICIPANT'S: • **Natural Children.** • **Stepchildren** who were enrolled in the Plan prior to the Participant's death. • **Legally Adopted Children.** • **Children for whom the Participant had been Appointed Legal Guardian.**	Updated Form, copy of Certified Birth Certificate and, if applicable, legally recognized documentation establishing custody and responsibility for health coverage (e.g. court order).	Updated Form. Contact the Trust Fund Office.
UNMARRIED PERMANENTLY DISABLED NATURAL CHILDREN OF THE DECEASED PARTICIPANT whose coverage would otherwise terminate due to attainment of age 26 may continue to be eligible, providing the Dependent meets Plan rules as outlined in the Summary Plan Description and any subsequent Summary of Material Modifications to the Plan.	Contact the Trust Fund Office.	Contact the Trust Fund Office.

HOW TO COMPLETE THE FORM

- Complete numbers 1 through 10 with the information of the Deceased Participant's Surviving Dependent.
- Confirm Health Plan Selection in number 11. Your eligible Dependent(s) will be enrolled in the same Health Plan.
- Complete numbers 12 through 13 (if applicable) and provide the Plan required documents. You MUST fully complete all subsections. **Attach additional Form(s) to enroll additional Dependents.**
- Read the **Kaiser Foundation Health Plan Arbitration Agreement** and **IMPORTANT NOTICE** above each signature line before you complete numbers 14 through 17.
- If you and/or any Dependent(s) have **Medicare, submit a copy of the card(s) with this Form.**

DISENROLLMENT PROCEDURES

If you wish to dis-enroll yourself and/or your eligible Dependent(s), a written request must be submitted to the Trust Fund Office.

If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Trust Fund Office.

If you are eligible for Medicare Benefits you must contact the Trust Fund Office for the required forms.

IMPORTANT: BECAUSE MEDICARE REQUIRES TIME TO PROCESS YOUR DISENROLLMENT REQUEST, FAILURE TO DISENROLL TIMELY MAY RESULT IN A LAPSE IN UTILIZING YOUR MEDICARE BENEFITS.

OVER →