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 OR BLUE SHIELD OF CALIFORNIA PPO / 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 black or blue ink; (b) is not completed in full; or (c) 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 SPOUSE INFORMATION

1. Legal Last Name, include Suffix (if applicable)	2. Legal 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 (Plus 4)

8. Marital Status	9. Are you Eligible for Medicare?	10.	11. Were you eligible for and enrolled under the Retiree Health and Welfare Plan at the time of Participant's death?
❑ 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	Home Phone ( ) - Cell Phone ( ) - Email Address: ______	❑ Yes ❑ No

HEALTH PLAN SELECTION

Your Selection is for your entire family. Please check one box only. Important: <u>You may only enroll and maintain enrollment in the Blue Shield of California HMO Plan if neither you nor any of your Dependents are Medicare eligible.</u> If you are enrolled/enrolling in the Blue Shield of California HMO Plan, you must designate a Primary Care Physician (PCP) and an IPA/Medical Group. If you fail to complete this section, Blue Shield will automatically assign you to a PCP/IPA Medical Group. You will be required to schedule appointments/services through your PCP/IPA Medical Group. Blue Shield HMO and Kaiser Permanente HMO Health Plan options have limitations in their coverage service areas. To enroll in the Blue Shield HMO Plan, the Surviving Dependent and all of his/her eligible Dependents must reside in a service area provided for under the Blue Shield of California HMO Plan. To enroll in the Kaiser Permanente HMO Plan, the Surviving Dependent and all of his/her eligible Dependents must reside in the Northern California Region Service Area provided for under the Kaiser Permanente HMO Plan.

12.	❑ Kaiser Permanente HMO Plan (Limited coverage area in California)	or	❑ Blue Shield of California PPO Plan (Nationwide coverage)	or	❑ Blue Shield of California HMO Plan (Limited coverage area in California) PCP (Primary/Personal Care Physician): ______ IPA/Medical Group Name: ______

DEPENDENT CHILD INFORMATION

<u>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.</u> Refer to reverse side for definitions of eligible Dependents.

13. **<u>Dependent Child</u> (Complete All Sections)** ❑ Natural Child ❑ Stepchild ❑ Other - Define: ______	Legal Last Name, include Suffix (if applicable)	Legal First Name	M.I.	Sex ❑ M ❑ F	Date of Birth / /	Social Security Number - -
	Address	City		State		Zip
	Is this Dependent Disabled? ❑ Yes ❑ No	Is there a Qualified Medical Child Support Order (QMCSO) or other Court Order pertaining to custody and responsibility for Health and Welfare coverage for this Dependent? (If yes, please submit a copy) ❑ Yes ❑ No				
	Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. Please be aware, this Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group. PCP (Primary/Personal Care Physician): ______ IPA/Medical Group Name: ______					

<u>Blue Shield of California Agreement</u>: Blue Shield participating providers may choose to enter into arbitration agreements with Blue Shield plan members, providing the agreement to arbitrate fully complies with California Code of Civil Procedure, Section 1295, including the provision that the patient is permitted to rescind the arbitration agreement in writing within 30 days of signature, even when medical services have already been provided. In addition, Authorization for Disclosure of Personal Information: by signing below, you authorize any "provider of care," insurer, plan, or your Blue Shield of California agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield of California to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. You understand that you are entitled to a copy of this form and that a photocopy is as valid as the original.

<u>Kaiser Foundation Health Plan Arbitration Agreement</u>

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 coverage 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.***

<u>IMPORTANT NOTICE:</u> I apply for health 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 and Kaiser Permanente or Blue Shield of California (as applicable).

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	Trust Fund Office Use Only
☐ - New Surviving Dependent ☐ - COBRA ☐ - Change ☐ - Audit Comments:	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, QMCSO, NMSN, Court Orders, 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: o **Natural Children.** o **Natural Children** under a Qualified Medical Child Support Order (QMCSO). o **Stepchildren** who were enrolled in the Plan prior to the Participant's death. o **Legally Adopted Children.** o **Children for whom the Participant had been Appointed Legal Guardian.**	Updated Form, copy of Certified Birth Certificate which names the deceased Participant as the Natural Parent and, if applicable, legally recognized documentation establishing custody and responsibility for health coverage (e.g. divorce decree or Qualified Medical Child Support Order [QMCSO]).	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 11 with the information of the Deceased Participant's Surviving Dependent Spouse.
- ❑ Choose a Health Plan Selection in number 12. Your eligible Dependent(s) will be enrolled in the same Health Plan.
- ❑ Complete number 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 applicable **Kaiser Foundation Health Plan, Inc., Arbitration Agreement** or **Blue Shield of California Agreement** and **IMPORTANT NOTICE** above the signature line before you complete numbers 14 through 17. Signature and date for numbers 14 and 15 are only required if you have selected Kaiser Permanente HMO Plan.
- ❑ If you and/or any Dependents 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→