



**THE EAST BAY
DRAYAGE DRIVERS
SECURITY FUND**

**Local 70 Health & Welfare Office
400 Roland Way
Oakland, CA 94621
(855) 263-7242 ♦ (925) 833-7301 FAX**

INSTRUCTIONS: (Please read carefully before completing this form)

You must complete and sign an Enrollment Form in order to obtain benefits under the Trust. If you are enrolling in or currently enrolled in Kaiser's HMO, you must also complete the HMO's Enrollment Form. See reverse for life insurance beneficiary designation.

You may ONLY change your plan options during the Open Enrollment period (July) after you first become eligible for coverage. If you are changing health plans, be sure to complete the entire box titled "CHOICE OF PLANS."

Check all That Apply I am a: CURRENT MEMBER

CHANGE OF:

NAME MARITAL STATUS MEDICAL PLAN

ADDRESS DEPENDENTS BENEFICIARY

COMPLETE ALL INFORMATION - PLEASE PRINT IN INK

PARTICIPANT DATA				
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			SEX (M/F)	DATE OF BIRTH
CITY	STATE	ZIP	TELEPHONE NUMBER	
DATE OF HIRE	EFFECTIVE DATE	EMPLOYER		

FAMILY DATA – Attach a marriage or birth certificate for each dependent				
FULL NAME	RELATIONSHIP**	SEX M/F	DATE OF BIRTH MONTH / DAY / YEAR	SOCIAL SECURITY #
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

**Relationship – Wife/Husband, Son, Daughter, Stepson, Stepdaughter, Other (Explain)

CHOICE OF PLANS	
<p>MEDICAL SELECTION – CHOOSE ONE:</p> <p><input type="checkbox"/> ANTHEM BLUE CROSS PPO</p> <p><input type="checkbox"/> KAISER PERMANENTE</p>	<p>DENTAL SELECTION – CHOOSE ONE:</p> <p><input type="checkbox"/> ANTHEM BLUE CROSS DPPO (CAN CHOOSE ANY DENTIST)</p>

(OVER FOR BENEFICIARY DESIGNATION)

DEATH BENEFIT BENEFICIARY

You may designate any person or persons you want to be your beneficiary(s) for the *Life Insurance Benefits* under the Plan. If you do not designate a beneficiary, your benefits will be paid to beneficiary(s) as provided for under the Plan. Please be sure to provide complete information, such as Jr., Sr., and middle names and initials, to avoid confusion. Please note that this designation applies only to life insurance benefits under the East Bay Drayage Drivers Security Fund.

BENEFICIARY OF DEATH BENEFIT

Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #
Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #
Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #
Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #
Beneficiary's Full Name and Address	Relationship	Date of Birth	Social Security #

IMPORTANT NOTICE: I apply for Health Plan membership for the person(s) listed on the reverse, and affirm under penalty of law that the information I have provided is true and complete. I agree that we shall abide by the provisions of the Health Maintenance Organization's (HMO) service agreement. I understand that the HMO's service agreement requires that all claims must be submitted to binding arbitration instead of court trial, including medical malpractice or other claims, which arise because I or my eligible dependents 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 me or my eligible dependents harm.

Please visit the East Bay Drayage Drivers' website at ebddsf.com to view additional Plan information and the Summary Plan Description (SPD), which includes your rights as a member.

It is your responsibility as a member to inform the Administrative Office of any qualifying event changes (marriage, divorce, newborn baby, etc.) when they first occur. If the Fund is not initially informed of your dependent losing their status as a dependent, they will be retroactively terminated on the qualifying event date, and you will be responsible for paying back any claims that were paid for by the Plan.

DATE _____

SIGNATURE _____

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER		
Company name		Hire date (mm/dd/yyyy)
Group number	Enrollment unit	Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON (see Change Table for assistance) New group: Yes No

New Hire (complete sections A, B, C, D) Open Enrollment (complete sections A, B, C, D)

Health Plan (Check one) HMO Plan Deductible Plan Other _____

Loss of Other Coverage (complete sections A, B, C, D) Other (please specify) _____

Name Change (complete sections A, B, C, D) From: _____ To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? Yes No

Medical Record No. (if known) _____ Social Security No. _____

Name (Last, First, MI) _____ Birth Date (mm/dd/yyyy) _____ Gender M F

Home Address _____ City _____ State _____ ZIP _____

Work Phone _____ Home Phone _____ Email _____

Ethnicity _____ Preferred Language _____

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Spouse/domestic partner name: Former last name (if any):		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Child <input type="checkbox"/> Student	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
Dependent name: Relationship:		

Do any of dependents above live at another address? Yes No If yes, complete the following:

Name (Last, First, MI): _____ Address: _____

D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any 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), Kaiser Permanente Insurance Company (KPIC),* 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 or coverage by KPIC, 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 and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2), the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3), the KPIC Dental Plans.

Signature Required for all Kaiser Permanente Plans
(Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans)

Date



California Region Group Enrollment/Change Form

General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information.

Section A: The subscriber must complete this section.

Section B: The subscriber must always complete this section. Use the Change Table (below) for assistance.

Section C: The subscriber must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

Section D: The subscriber must sign and date this section.

Change Table

Add dependent

	Event date
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent

	Event date
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

Demographic Change

	Event date
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.