THE EAST BAY DRAYAGE DRIVERS SECURITY FUND

Local 70 Health & Welfare Office
400 Roland Way
Oakland, CA 94621

(855) 263-7242 ♦ FAX (925) 405-0659
kachan@corcoranadmin.com

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 marked "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	EMAIL ADDRESS (OPTIONAL)	

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

MEDICAL SELECTION – **CHOOSE ONE:**

☐ ANTHEM BLUE CROSS PPO ☐ ANTHEM HMO

☐ KAISER PERMANENTE HMO GRP #38-____

DENTAL SELECTION – **CHOOSE ONE:**

☐ ANTHEM BLUE CROSS DPPO
(**CAN CHOOSE ANY DENTIST**)

PAGE 2 - SIGNATURE REQUIRED & BENEFICIARY DESIGNATION

PAGE 3 - 2ND SIGNATURE REQUIRED FOR KAISER ENROLLEES

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** _____

Last Name:_____ First Name:_____

For employees enrolling in a Kaiser Permanente Health Plan in California:

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.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

Note: Kaiser requires that this arbitration agreement be signed. The arbitration agreement does not apply to claims that are subject to ERISA claims and appeals procedure rules. If you do not wish to accept the Kaiser arbitration agreement, you must make a new medical plan selection.

California Large Commercial Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name: East Bay Drayage Drivers Security Fund

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30)

Employee Number/ID

Effective date of enrollment/change* (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition for obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth* (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan 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*.

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following 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.

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

3 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City State ZIP code

If you prefer, you may complete this enrollment/change transaction online by visiting **account.kp.org**.

*Field required for all enrollments and changes.