MEDICAL AND DENTAL PLAN ENROLLMENT FORM - ACTIVE

Southern California IBEW-NECA Health Plan

6023 Garfield Avenue, City of Commerce, California 90040

Mailing Address: P.O. Box 910918, Los Angeles, CA 90091

(323) 221-5861 or (800) 824-6935 (Nationwide) Fax No.: (323) 726-3520 website: www.scibew-neca.org

PART 1: MUST SELECT ONE:

☐ **NEW ENROLLMENT** ☐ **CARRIER CHANGE**

PART 2: GENERAL INFORMATION

❶ READ THE INSTRUCTIONS ON THIS FORM CAREFULLY. YOU NEED TO FILL OUT THIS FORM COMPLETELY.

❷ PLEASE PRINT IN BLACK OR BLUE INK OR TYPE CLEARLY.

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER
			___ – ___ – ____

STREET ADDRESS – **DO NOT USE P.O. BOX**	APT #:	CITY	STATE	ZIP CODE

DATE OF BIRTH	TELEPHONE NUMBER	GENDER	LOCAL UNION NUMBER
	( )	☐ MALE ☐ FEMALE	#**11**

MARITAL STATUS

☐ SINGLE, NEVER MARRIED	☐ MARRIED or RE-MARRIED DATE OF MARRIAGE: _____ (INCLUDE A COPY OF YOUR CERTIFIED MARRIAGE CERTIFICATE WITH THIS FORM)
☐ DIVORCED/LEGALLY SEPARATED/ANNULMENT (INCLUDE A COPY OF YOUR JUDGMENT OF DISSOLUTION WITH THIS FORM)	

PREFFERRED LANGUAGE SELECTION

DO YOU HAVE A PREFERRED LANGUAGE, OTHER THAN ENGLISH? ☐ NO ☐ YES - LANGUAGE: _____ ☐ DECLINE TO RESPOND

PREFERRED LANGUAGE FOR YOUR SPOUSE, OTHER THAN ENGLISH? ☐ NO ☐ YES - LANGUAGE: _____ ☐ DECLINE TO RESPOND

PART 3: PLAN SELECTIONS

MEDICAL PLAN SELECTION - SELECT ONE PLAN ONLY (MUST SIGN ARBITRATION AGREEMENT ON PAGE 3)

☐ ANTHEM BLUE CROSS PRUDENT BUYER (PPO) - #170001M004	
☐ KAISER PERMANENTE (HMO) #101155-00	(IF YOU ARE SELECTING KAISER OR UNITEDHEALTHCARE, YOU MUST LIVE WITHIN THE HMO SERVICE AREA)
☐ UNITEDHEALTHCARE (HMO) #144786	UNITEDHEALTHCARE PHYSICIAN CODE REQUIRED:

DENTAL PLAN SELECTION - SELECT ONE PLAN ONLY

☐ UNITED CONCORDIA (PPO) #894200-00	(IF YOU ARE SELECTING DHMO: DELTACARE, CIGNA UNITED CONCORDIA – FACILITY CODE REQUIRED)
☐ DELTACARE (DHMO) #71175-00001	DHMO FACILITY CODE REQUIRED:
☐ CIGNA DENTAL CARE (DHMO) #3217300	DHMO FACILITY CODE REQUIRED:
☐ UNITED CONCORDIA (DHMO) #740284	DHMO FACILITY CODE REQUIRED:

Southern California IBEW-NECA Administrative Corporation

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

PART 4: FAMILY INFORMATION – PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS TO BE ENROLLED

CHANGE IN MARTIAL STATUS ACKNOWLEDGEMENT (PARTICIPANT SIGNATURE REQUIRED)

I understand that the Southern California IBEW-NECA Health Trust Fund Board of Trustees reserves the right to require additional proof at any time of ongoing dependent eligibility and may conduct periodic audits to confirm eligibility status of all dependents. I understand it is my responsibility to promptly notify the Administrative Trust Funds Office in writing with appropriate documentation if there is any change in my marital status.

PARTICIPANT SIGNATURE REQUIRED	DATE SIGNED
X	/ /

SEE LIST OF ELIGIBLE PLAN PARTICIPANTS AND REQUIRED DOCUMENTATION

RELATIONSHIP: ☐ SPOUSE – FEMALE ☐ SPOUSE – MALE	DATE OF BIRTH
FIRST NAME / MIDDLE INITAL / LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:	☐ CERTIFIED MARRIAGE CERTIFICATE INCLUDED

RELATIONSHIP: ☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER	DATE OF BIRTH
FIRST NAME / MIDDLE INITAL / LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:	☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED

RELATIONSHIP: ☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER	DATE OF BIRTH
FIRST NAME / MIDDLE INITAL / LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:	☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED

RELATIONSHIP: ☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER	DATE OF BIRTH
FIRST NAME / MIDDLE INITAL / LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:	☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED

RELATIONSHIP: ☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER	DATE OF BIRTH
FIRST NAME / MIDDLE INITAL / LAST NAME	SOCIAL SECURITY NUMBER
IF SELECTING UNITEDHEALTHCARE, PLEASE SELECT A PRIMARY PHYSICIAN CODE:	☐ CERTIFIED BIRTH CERTIFICATE OR LEGAL GUARDIANSHIP INCLUDED

PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

PART 5: PARTICIPANT ACKNOWLEDGEMENT (REQUIRED SIGNATURE)

I understand this election will remain in effect so long as I remain eligible, or until I make another election during an enrollment period. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, or Pharmacist to release any information requested to pay any claim under the plan selected. I want to enroll myself and those eligible members of my family listed above for participation in the plan elected. I understand that it is my responsibility to report any changes in the eligibility of my dependents; that the benefits and services of the elected plans are coordinated with those provided by any other group hospital, medical benefit, dental plan or service plan. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any Plan (Kaiser Permanente, UnitedHealthcare, Anthem Blue Cross, DeltaCare, United Concordia, Cigna Dental, Vision Service Plan) member and any such Plan (including its agents, staff physicians, employees and providers) is subject to binding arbitration.

PARTICIPANT SIGNATURE REQUIRED FOR ALL PLAN CHANGES/ENROLLMENTS	DATE SIGNED
X	/ /

PART 6: ARBITRATION AGREEMENT

ANTHEM BLUE CROSS (PPO) ARBITRATION AGREEMENT: PLEASE READ AND SIGN

REQUIREMENT FOR BINDING ARBITRATION: ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration*. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

SIGNATURE REQUIRED FOR ANTHEM BLUE CROSS PLAN PARTICIPANT	DATE
X	/ /

KAISER PERMANENTE (HMO) ARBITRATION AGREEMENT: PLEASE READ AND SIGN

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 KAISER PERMANENTE PLAN PARTICIPANT	DATE
X	/ /

UNITEDHEALTHCARE HEALTH PLAN (HMO) ARBITRATION AGREEMENT: PLEASE READ AND SIGN

I agree and understand that any and all disputes, including claims relating to the delivery of services under the Pan and claims of medical malpractice (that is, as to whether any medical services rendered under the Health Plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the Plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

SIGNATURE REQUIRED FOR UNITEDHEALTHCARE PLAN PARTICIPANT	DATE
X	/ /

FOR OFFICE USE ONLY

NOTES	REASON	MEDICAL	DENTAL	EFFECTIVE DATE OF COVERAGE			DOCUMENTS RECEVIED
				MONTH	DAY	YEAR	
	☐ NEW ENROLLMENT ☐ CARRIER CHANGE						DATE RECEIVED: _____ BY: _____ ☐ MARRIAGE CERT ☐ JUDGMENT OF DISSOLUTION ☐ BIRTH CERT ☐ ADOPTION DOCUMENTS ☐ LEGAL GUARDIANSHIP

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PARTICIPANT INFORMATION			
FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER

ADDITIONAL INFORMATION:

LIST OF ELIGIBLE DEPENDENTS UNDER THE ACTIVE HEALTH PLAN:	PLEASE INCLUDE THE REQUIRED DOCUMENTATION WITH THIS ENROLLMENT FORM:
SPOUSE	CERTIFIED MARRIAGE CERTIFICATE
BIOLOGICAL CHILDREN TO AGE 26	CERTIFIED BIRTH CERTIFICATE/PATERNITY TEST/QMCSO
STEP CHILDREN TO AGE 26	CERTIFIED BIRTH CERTIFICATE
ADOPTED CHILDREN TO AGE 26	ADOPTION AFFIDAVIT
PERMANENTLY DISABLED CHILDREN	CERTIFIED BIRTH CERTIFICATE/PATERNITY TEST/ ADOPTION OR GUARDIANSHIP AFFIDAVIT
CHILD WHO IS A WARD UNDER ORDER OF TEMPORARY OR PERMANENT GUARDIANSHIP	LEGAL GUARDIANSHIP DOCUMENTATION
TEMPORARY DISABLED CHILD	DISABILITY APPLICATION/CERTIFIED BIRTH CERTIFICATE – CHILD SUBJECT TO TEMPORARY OR PERMANENT GUARDIANSHIP

SAMPLE OF ACCEPTABLE DOCUMENTS BELOW:

Marriage Certificate
A certified marriage certificate proves you did get married and recorded with the county clerk's office. This is an approved verification document.

Birth Certificate
For a birth certificate to be accepted, it must contain the parent(s) name and be issued by the county or state to prove relationship status.

Marriage License
A marriage license only proves you filed for a license and is **NOT** an approved verification document.

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