Northern California Plasterers Trust Funds

Health & Welfare Trust Fund, Pension Plan and Plasterers Local 66 Supplemental Pension Trust
4160 Dublin Boulevard, Suite 400, Dublin, CA 94568-7756
Toll Free: 1-(844) 663-8121 * Fax: 1-(925) 833-7301
Email: plasterersinfo@hsba.com
Website: http://www.plasterersbenefits.com

ACTIVE ENROLLMENT FORM

The annual Open Enrollment for the Northern California Plasterers Health and Welfare Trust Fund runs from **JUNE 01 through JUNE 30**; each year you have the opportunity to make changes to your Medical and Dental coverage.

DEPENDENTS ELIGIBILITY

Only the following are eligible for dependents insurance:

- Your lawful spouse.
- Your domestic partner (subject to Plan rules).
- Your natural-born child or your adopted child or child placed with you from moment of placement during adoption proceeding up to age 26.
- Your stepchild up to age 26.
- A foster child up to age 26.

A mentally or physically disabled child who reaches his/her 26th birthday while insured under the policy may be continued if the child:

I. Is chiefly dependent on you for support; and
II. Is not capable of self-sustaining employment; and
III. You give us proof of the child's disability:
   - Not later than 31 days after the child attains the limiting age; and
   - Thereafter as the Trustees may require, but not more than once every two years.

Dependent eligibility begins on the later of the day you become insured under the Plan, or the day you first acquire an eligible dependent provided that you notify the Administration Office.

TO ADD OR CHANGE A DEPENDENT, THE FOLLOWING DOCUMENTATION MAY BE REQUIRED:

- For addition or deletion of spouse: copy of the original marriage certificate or divorce papers, as applicable.
- For addition or deletion of domestic partner: copy of the California Secretary of State Domestic Partnership filings.
- For addition of a natural-born child: copy of the original birth certificate.
- For addition of a foster child or adopted child: legal guardianship or court adoption papers.

Eligibility for all persons listed on this page is subject to all provisions and limitations of the Trust Agreement and Plan Document (as amended) as well as to any rules or regulations adopted by the Board of Trustees. No coverage is provided for a dependent while that dependent is in full-time military service.

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ACTIVE ENROLLMENT FORM for NEW AND OPEN ENROLLMENT

☐ NEW MEMBER *OR* CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ PLAN ☐ BENEFICIARY ☐ DEPENDENTS ☐ NEWBORN ☐ MARRIAGE ☐ DIVORCE
☐ CHANGE OF ADDRESS OR ☐ OTHER: _____

Participant Data

FIRST NAME	LAST NAME	M.I	SOCIAL SECURITY #:
MAILING ADDRESS (STREET OR P.O.BOX)		SEX	DATE OF BIRTH
CITY ST/ZIP	HOME PHONE NUMBER		CELL PHONE NUMBER
EMAIL ADDRESS	MARITAL STATUS/ DATE OF DIVORCE OR MARRIAGE		EMPLOYER/ LOCAL #:

CHOICE OF PLANS:
MEDICAL PLAN SELECTION – CHOOSE ONE:

- ☐ Kaiser HMO
- ☐ Blue Shield HMO
- ☐ Blue Shield PPO *(Only available to members who live outside the HMO service areas)*

CHOICE OF PLANS:
DENTAL PLAN SELECTION – CHOOSE ONE:

- ☐ Premier Access DHMO
- ☐ Premier Access PPO
- ☐ Opt out of Dental/Vision (NO FINANCIAL SAVINGS)

Dependent Data

FULL NAME Please add Dependents' names below	RELATION	SEX	DATE OF BIRTH	SOCIAL SECURITY#	RECEIVING MEDICARE PART A OR B	KIDNEY TRANSPLANT OR DIALYSIS
SPOUSE OR DOMESTIC PARTNER:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						
DEPENDENT:						

Life Insurance

Primary Beneficiary's Full Name &Address	Social Security #	Date of Birth	%

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Primary Beneficiary's Full Name &Address	Social Security #	Date of Birth	%
Primary Beneficiary's Full Name &Address	Social Security #	Date of Birth	%

Kaiser Permanente Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, or other associated parties on the one hand and Kaiser Permanente Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, 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 my 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.

Name: _____ Signature: _____ Date: _____

YOU MUST SIGN IN ORDER TO PROCESS YOUR "KAISER" ENROLLMENT SELECTION. FAILURE TO SIGN ABOVE WILL RESULT IN BEING ENROLLED

YOU MUST SIGN BELOW IN ORDER TO PROCESS YOUR ENROLLMENT APPLICATION:

YOUR FULL NAME:	SIGNATURE:	DATE:
_____	_____	_____