

**INSTRUCTIONS** Please also read the important information on the back of the form.

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health & Welfare coverage. Be sure to complete **all** of the information requested on the Enrollment Form. Under the terms of your coverage, you may only make an election of a Medical and a Dental Plan if you have Plan A coverage. If you move into the Plan A coverage you can request to enroll in an HMO from when your Plan A coverage becomes effective through the end of the next Open Enrollment Period. Be sure to complete the box marked COVERAGE SELECTION if you are requesting a Plan change.

Please read your Summary Plan Description for descriptions of the various plans. Remember, once you make the election you will not be permitted to change your Plan until the next annual Open Choice period which is during the month of November each year (changes effective January 1).

**TO ADD OR CHANGE COVERAGE FOR YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION IS REQUIRED**

- Copies of certified Marriage Certificate or Divorce papers must be submitted.
- Copies of Certificate of Registration of Domestic Partnership must be submitted if you are adding a Domestic Partner.
- Copies of certified Birth Certificates must be submitted for dependent children.
- Stepchildren, including any children of your Domestic Partner must live with and be primarily dependent on you for support. Verification of support required on request.
- Foster & Adopted children: Legal Guardianship or Court adoption papers are required. The child/children must live with you.
- Form certifying full-time student status required for dependent children ages 19-23.

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES.

**NEW ENROLLMENT / TRANSFER**

Date of Hire: \_\_\_\_\_  
 Employer: \_\_\_\_\_

**NEW HIRE**

**TRANSFER TO Northern California – Same Employer**

Prior Job Location/Local: \_\_\_\_\_  
 Date of Transfer: \_\_\_\_\_

**TRANSFER FROM RECIPROCAL FUND If Reciprocal Fund in Southern California Wholesale Butchers, attach REQUEST FOR TRANSFER OF CREDITS FORM**

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**NOTIFICATION OF CHANGE**

CHANGE OF NAME  
 CHANGE OF MARITAL STATUS  
 CHANGE OF DEPENDENTS  
 CHANGE OF BENEFICIARY  
 CHANGE OF PLAN  
 RETURN FROM MILITARY SERVICE (Attach copy of Form DD-214)

**Section 1 COVERAGE SELECTION**

**Medical Plan (Plan A only have HMO options)**

I select:  Indemnity Open Plan (PPO)  Kaiser\*  Health Net

\*If you select Kaiser and were previously covered by Kaiser, please provide your Kaiser Medical Record # in Section 2 and for other family members in Section 3.

**Dental Plan (A and B only)**

Delta Dental

**Section 2 PARTICIPANT / EMPLOYEE INFORMATION**

Last Name		First Name		Initial	Gender	Social Security #		Union Local
Mailing Address (Street or P. O. Box)				<input type="checkbox"/> New	City	State	Zip Code	
Telephone Number	Current Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Date of Marriage/Divorce (MM/YY)	Date of Birth (MM/DD/YY)	Kaiser Medical Record#		
Email								

**Section 3 DEPENDENT(S) INFORMATION (Dependent coverage for Plan C applies only after 18 months of Plan C Employee only coverage)**

Last Name	First Name	Relation	Gender	Date of Birth (MM/DD/YY)	Dependent Social Security# (Required)	Kaiser Medical Record#
<b>Spouse/Domestic Partner</b>						
<b>Dependent 1</b>						
<b>Dependent 2</b>						
<b>Dependent 3</b>						

**Section 4 BENEFICIARY OF DEATH BENEFIT**

Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code
Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code
Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code

**SIGNATURE REQUIRED ON BACK**

**Section 5 SPOUSE EMPLOYMENT AND OTHER INSURANCE**

Is your spouse currently employed?  Yes  No If 'No', skip rest of Section 5. If 'Yes', please provide the following information:

Name of Spouse's Employer: \_\_\_\_\_ Employer's Telephone: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Does your Spouse's Employer provide any health insurance coverage or funds which can be used for Insurance coverage?  Yes  No If 'No', skip rest of Section 5.

**Please note that under Plan Rules your Spouse's failure to obtain health insurance coverage provided by his/her Employer may result in a reduction of benefits provided by this Plan for an eligible Spouse. This applies to participants with Plan A, Plan B and Plan C – (Family coverage 19<sup>th</sup> – 36<sup>th</sup> month of eligibility under Plan C)**

If your Spouse is enrolled in a Plan, mark the 'Yes' box and provide information about the Insurance Carrier. If your Spouse is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Enrolled in Medical/Rx Plan?  Yes Effective date: \_\_\_\_\_ Carrier: \_\_\_\_\_ Plan covers:  Employee only  Employee and Family Check here if HMO   
 No **Check one of the following:**  Not offered by Employer  Offered by Employer Employee monthly cost: \$ \_\_\_\_\_

Enrolled in Dental Plan?  Yes Effective date: \_\_\_\_\_ Carrier: \_\_\_\_\_ Plan covers:  Employee only  Employee and Family  
 No **Check one of the following:**  Not offered by Employer  Offered by Employer Employee monthly cost: \$ \_\_\_\_\_

Enrolled in Vision Plan?  Yes Effective date: \_\_\_\_\_ Carrier: \_\_\_\_\_ Plan covers:  Employee only  Employee and Family  
 No **Check one of the following:**  Not offered by Employer  Offered by Employer Employee monthly cost: \$ \_\_\_\_\_

Next Open Enrollment Period for Spouse's Employer Month: \_\_\_\_\_ Year: \_\_\_\_\_

**Section 6 OTHER INSURANCE COVERAGE FOR YOU OR ANY ENROLLED DEPENDENT CHILDREN**

Are you covered by Medicare?  No  Yes Is your Spouse covered by Medicare?  No  Yes

Are you covered by any other Group Insurance?  No  Yes Other Insurance Carrier: \_\_\_\_\_

Are any of your dependent(s) covered by any other Group Insurance?  No  Yes Other Insurance Carrier Covered dependent name(s) \_\_\_\_\_

**Section 7 PARTICIPANT AND SPOUSE CERTION (PLEASE READ THE INFORMATION BELOW AND SIGN)**

**FRAUD NOTICE:** I UNDERSTAND THAT I MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTIES FOR COMMITTING A FRAUDULENT INSURANCE ACT IF I KNOWINGLY PROVIDE ANY MATERIALLY FALSE INFORMATION TO, OR CONCEAL ANY MATERIAL FACTS FROM, THE TRUST FUND WITH THE INTENT TO DEFRAUD OR MISLEAD THE TRUST FUND.

**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION:** I AUTHORIZE MY PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN LISTED ABOVE, OR THE TRUST FUND ANY AND ALL INFORMATION OR RECORDS PERTAINING TO MEDICAL HISTORY, INCLUDING SERVICES RENDERED, OR TREATMENT GIVEN TO ANYONE ENROLLED NOW OR ADDED LATER FOR THE PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM INTERNAL ADMINISTRATIVE FUNCTIONS. I UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY CONFIDENTIAL INFORMATION TO OTHERS. ANY SUCH DISCLOSURE SHALL BE MADE IN COMPLIANCE WITH ALL APPLICABLE LAWS. THE TRUST FUND, ITS AGENTS OR EMPLOYEES, SHALL USE ALL REASONABLE SAFEGUARDS TO ENSURE THAT ANY USE OR DISCLOSURE OF MY CONFIDENTIAL INFORMATION IS SOLELY FOR THE PURPOSE OF ADMINISTERING BENEFITS UNDER THE PLAN.

**ARBITRATION:** I AGREE THAT ANY DISPUTE OR CONTROVERSY WHICH MAY ARISE BETWEEN MYSELF OR ANY FAMILY MEMBER AND A PREPAID PLAN OR HEALTH MAINTENANCE ORGANIZATION (HMO), OR ANY OF ITS PROVIDERS, SHALL BE SETTLED BY THE PREPAID PLAN'S OR HMO'S FINAL AND BINDING ARBITRATION RULES, IF ANY.

**SPOUSE/DOMESTIC PARTNER'S CONSENT TO DISCLOSURE OF SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION:** BY MY SIGNATURE BELOW, I AUTHORIZE THE TRUST FUND TO OBTAIN MY SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION FROM MY EMPLOYERS FOR PURPOSES OF DETERMINING MY ELIGIBILITY AS A SPOUSE UNDER THE PLAN.

**SIGNATURE**

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM, WHICH I HAVE FULLY READ AND UNDERSTAND.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Spouse's Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Or  
Domestic Partner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_