AUTOMOTIVE INDUSTRIES WELFARE FUND

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NEW PARTICIPANT ENROLLMENT FORM

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	MAIN NUMBER	MOBILE NUMBER
			( ) -	( ) -

E-MAIL ADDRESS	EFFECTIVE DATE OF COVERAGE

MARITAL STATUS	DATE OF MARRIAGE / DIVORCE DOMESTIC PARTNER REGISTRATION	EMPLOYER	DATE OF HIRE
☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED		OCCUPATION/CLASSIFICATION:	LOCAL #

MEDICAL SELECTION

HMO PLAN:

☐ **KAISER PERMANENTE –** GRP #57 & EU 0

DENTAL SELECTION

DHMO PLAN:

☐ **UNITED HEALTHCARE DENTAL –** GRP #711992
☐ **METLIFE –** GRP #142616
☐ **UNITED CONCORDIA PLUS –** GRP #740306

OPT-OUT SELECTION

☐ **MEDICAL & PRESCRIPTION DRUG PLAN**
☐ **ANCILLARY BENEFITS**
(DENTAL, VISION, ORTHODONTIA, DISABILITY & LIFE)

NEWLY ELIGIBLE PARTICPANTS MUST ENROLL IN THE PPO MEDICAL PLAN AND A DHMO DENTAL PLAN FOR THE FIRST 12 MONTHS OF COVERAGE. PARTICIPANT MAY BE ELIGIBLE FOR ADDITIONAL SELECTION OF MEDICAL AND/OR DENTAL PLANS. PLEASE CONTACT THE TRUST FUND OFFICE FOR INFORMATION ON ENROLLMENT REQUIREMENTS.

I AM ELECTING PLAN COVERAGE FOR:

☐ **SINGLE PARTY** [SELF]
☐ **2-PARTY** [SELF + 1]
☐ **FAMILY** [SELF + 2 OR MORE]

- AND / OR –

I WISH TO OPT OUT OF ENROLLING:

☐ **MYSELF***
☐ **MY SPOUSE OR DOMESTIC PARTNER**
☐ **MY DEPENDENT CHILDREN**

FOR OFFICIAL USE ONLY **KASIER PLAN ACCORDING TO SUBSCRIBER AGREEMENT**
☐ **K20** ☐ **K500** ☐ **K1000**

PERSONAL & DEPENDENT INFORMATION

RELATION*	LAST NAME	FIRST NAME	M.I.	SEX	DISABLED	DATE OF BIRTH	SOCIAL SECURITY NO.	RECEIVING MEDICARE PART A OR B	KIDNEY TRANSPLANT OR DIALYSIS
SELF								❑ YES ❑ NO	❑ YES ❑ NO
□ SPOUSE □ DOMESTIC PARTNER**								❑ YES ❑ NO	❑ YES ❑ NO
DEPENDENT*								❑ YES ❑ NO	❑ YES ❑ NO
DEPENDENT*								❑ YES ❑ NO	❑ YES ❑ NO

*** RELATION – SON, DAUGHTER, STEPSON, STEPDAUGHTER, ETC. PLEASE SEE REVERSE SIDE FOR EXPLANATION OF "WHO IS ELIGIBLE".**
****DOMESTIC PARTNER – DOMESTIC PARTNERS MUST PROVIDE A STATE OF CALIFORNIA DECLARATION OF DOMESTIC PARTNERSHIP OR OTHER LOCAL REGISTRY DOCUMENT, AS APPROPRIATE, TO GAIN ELIGIBILITY.**

COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF THE MEDICARE CARD IF YOU OR A DEPENDENT(S) ARE ENROLLED IN MEDICARE

PLEASE LIST THE INDIVIDUAL RECEIVING MEDICARE		
NAME:_____	RECEIVING PART A? YES ☐ NO ☐	EFFECTIVE DATE A: _____/_____/_____
	RECEIVING PART B? YES ☐ NO ☐	EFFECTIVE DATE B: _____/_____/_____

YOU MUST COMPLETE IF YOU CHECKED YES TO TRANSPLANT OR RECEIVING KIDNEY DIALYSIS

PLEASE LIST THE INDIVIDUAL RECEIVING DIALYSIS OR TRANSPLANT		
NAME:_____	RECEIVED KIDNEY TRANSPLANT YES ☐ NO ☐	DATE OF TRANSPLANT: _____/_____/_____
	RECEIVING DIALYSIS YES ☐ NO ☐	DATE OF FIRST TREATMENT: _____/_____/_____

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION(S)

I UNDERSTAND THIS ELECTION WILL REMAIN IN EFFECT SO LONG AS I REMAIN ELIGIBLE, OR UNTIL I MAKE ANOTHER ELECTION DURING AN ELIGIBLE CHANGE 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, UNITED HEALTHCARE DENTAL, METLIFE, UNITED CONCORDIA PLUS, SELF-FUNDED DENTAL PLAN/DELTA BASIC OR VSP) MEMBER AND ANY SUCH PLAN (INCLUDING ITS AGENTS, STAFF PHYSICIANS, EMPLOYEES AND PROVIDERS) IS SUBJECT TO BINDING ARBITRATION.

EMPLOYEE SIGNATURE: _____ **DATE**: _____

PLEASE SEE AND READ THE REVERSE SIDE FOR IMPORTANT NOTICES, ACKNOWLEDGEMENTS & AGREEMENTS BEFORE SIGNING.

WHO IS ELIGIBLE?

INSTRUCTIONS: (PLEASE READ CAREFULLY BEFORE COMPLETING THE "ENROLLMENT FORM")

THE ENROLLMENT FORM MUST BE COMPLETED IN ORDER TO ENROLL YOU AND YOUR DEPENDENTS, IF APPLICABLE, FOR HEALTH & WELFARE COVERAGE UNDER ONE OF THE FUND'S PLANS. BE SURE TO COMPLETE ALL OF THE INFORMATION REQUESTED ON THE ENROLLMENT FORM. UNDER THE TERMS OF YOUR COVERAGE, YOU MAY MAKE AN ELECTION OF THE MEDICAL AND DENTAL PLAN. BE SURE TO COMPLETE THE BOX MARKED "CHOICE OF PLANS."

PLEASE READ YOUR SUMMARY PLAN DESCRIPTION FOR DESCRIPTIONS OF THE VARIOUS PLANS. REMEMBER, ONCE YOU MAKE THE ELECTION, CHANGES ARE ONLY PERMITTED ONCE IN A 12-MONTH PERIOD.

TO ADD OR CHANGE YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION MAY BE REQUIRED.

- COPIES OF CERTIFIED MARRIAGE CERTIFICATE OR DIVORCE PAPERS.
- COPIES OF CERTIFIED BIRTH CERTIFICATES FOR DEPENDENT CHILDREN
- FOSTER & ADOPTED CHILDREN: LEGAL GUARDIANSHIP OR COURT ADOPTION PAPERS

DEPENDENT ELIGIBILITY AND ENROLLMENT

IF YOU QUALIFY FOR BENEFITS, THE FOLLOWING DEPENDENTS MAY BE COVERED:

- YOUR LAWFUL SPOUSE
- REGISTERED DOMESTIC PARTNERS
- UNMARRIED CHILDREN WHO ARE LESS THAN 26 YEARS OF AGE. THE DEFINITION OF UNMARRIED CHILDREN ARE THOSE DECLARED BY YOU AS DEPENDENTS FOR FEDERAL INCOME TAX PURPOSES AND INCLUDE YOUR:
  - NATURAL CHILDREN
  - STEPCHILDREN
  - LEGALLY ADOPTED CHILDREN FROM THE TIME THEY ARE PLACED IN YOUR CUSTODY
  - CHILDREN FOR WHOM ADOPTION PROCEEDINGS HAVE BEEN STARTED
  - CHILDREN FOR WHOM YOU HAVE BEEN LEGALLY APPOINTED GUARDIAN
  - ANY CHILD REQUIRED TO BE RECOGNIZED UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER WHO IS LESS THAN 26 YEARS OF AGE (21 FOR LIFE INSURANCE).
- ANYSPOUSE, REGISTERED DOMESTIC PARTNER OR CHILD WHO IS ELIGIBLE UNDER THE PLAN AS AN ACTIVE OR RETIRED PARTICIPANT WILL NOT ALSO BE CONSIDERED ELIGIBLE AS A DEPENDENT.
- A CHILD WILL NOT BE CONSIDERED A DEPENDENT FOR MORE THAN ONE ELIGIBLE ACTIVE OR RETIRED PARTICIPANT.
- DISABLED DEPENDENT CHILDREN OVER AGE 26 AND INCAPABLE OF SELF-SUPPORTING EMPLOYMENT BECAUSE OF MENTAL RETARDATION OR PHYSICAL HANDICAP WILL HAVE ELIGIBILITY EXTENDED.

ELIGIBILITY FOR ALL PERSONS LISTED ABOVE 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.

OPT-OUT PROVISIONS

IN ORDER TO OPT BACK IN TO A SPECIFIC BENEFIT COVERAGE, A HIPAA SPECIAL ENROLLMENT EVENT MUST OCCUR AND THE TRUST FUND OFFICE MUST BE NOTIFIED WITHIN 31 DAYS. FOR EXAMPLE, A QUALIFYING EVENT WOULD BE A DIVORCE, SPOUSE COVERAGE TERMINATION DUE TO LOSS OF EMPLOYMENT, BIRTH OR ADOPTION OF A CHILD, ETC. UPON SELECTION OF AN OPT-OUT, THE TRUST FUND OFFICE WILL SEND THE PARTICIPANT A LETTER EXPLAINING THE REQUIREMENT TO RE-ENTER THE PLAN. COVERAGE UNDER AN OPT-IN REQUEST WILL BEGIN THE FIRST OF THE MONTH FOLLOWING 31 DAYS AFTER RECEIPT OF A COMPLETED OPT-IN FORM.

BENEFICIARY DESIGNATION

THIS ENROLLMENT FORM PROVIDES FOR YOU TO NAME A BENEFICIARY TO YOUR *BURIAL BENEFITS*, AND *DEATH AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS* UNDER THE FUND. LIST AS P=PRIMARY OR C=CONTINGENT. ENTER THE FULL NAME & ADDRESS, % ALLOCATION OF DISTRIBUTIONS, RELATIONSHIP TO YOU, THE DATE OF BIRTH, AND SOCIAL SECURITY NUMBER FOR EACH BENEFICIARY SHOWN BELOW.

BY SIGNING THIS, YOU UNDERSTAND THAT IF YOU ARE MARRIED OR IN A REGISTERED DOMESTIC PARTNERSHIP BUT DO NOT NAME YOUR SPOUSE OR DOMESTIC PARTNER AS A BENEFICIARY, S/HE MAY STILL BE ENTITLED TO A COMMUNITY PROPERTY SHARE OF YOUR "LUMP SUM CONTRIBUTIONS" OR A SHARE OF ANY MONTHLY ALLOWANCE THAT MAY BE PAYABLE. YOUR "NON-SPOUSE OR NON-PARTNER" DESIGNATED BENEFICIARIES WILL RECEIVE THE PORTION OF YOUR LUMP SUM BENEFITS, WHICH ARE NOT PAYABLE TO YOUR SPOUSE OR DOMESTIC PARTNER AS HIS/HER COMMUNITY PROPERTY SHARE. YOU FURTHER UNDERSTAND THAT IF YOUR DEATH IS DETERMINED TO BE "INDUSTRIAL," SPECIAL DEATH BENEFITS WILL BE PAID IN THE MANNER PRESCRIBED BY LAW. IF NO PERCENTAGE (%) IS GIVEN, THE APPLICABLE BENEFITS WILL BE PAID IN EQUAL PORTIONS. YOUR SPOUSE OR DOMESTIC PARTNER MAY WAIVE HIS/HER RIGHTS TO COMMUNITY PROPERTY BEFORE A NOTARY PUBLIC AS PRESCRIBED BY LAW.

P/C	FULL NAME AND ADDRESS	%	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO.

YOUR SIGNATURE CONFIRMS THE BENEFICIARY DESIGNATION SHOWN ABOVE.

EMPLOYEE SIGNATURE: _____ **DATE**: _____