CMTA-IAM JOINT RETIREE HEALTH & WELFARE PLAN

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RETIREE 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	TELEPHONE NUMBER ( )

MARITAL STATUS	DATE OF MARRIAGE/DIVORCE	ARE YOU ELIGIBLE FOR MEDICARE?	I AM ELECTING COVERAGE FOR:
☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED		☐ YES, ATTACH COPY OF CARD ☐ NO	☐ SINGLE PARTY [SELF] ☐ 2-PARTY [SELF + 1] ☐ FAMILY [SELF + 2 OR MORE]

SEE THE FOLLOWING INSERTS FOR MEDICAL & PRESCRIPTION DRUG OR PRESCRIPTION DRUG ONLY COVERAGE OPTIONS AND RATES.

MEDICAL SELECTION

NON-MEDICARE

CALIFORNIA

☐ **KAISER PERMANENTE** *(Plan 767, EU 0 thru 7)*
- ☐ HMO
- ☐ DHMO

☐ **UNITED HEALTHCARE**
- ☐ HMO

OREGON

☐ **KAISER PERMANENTE (HMO)**

MEDICARE

CALIFORNIA

☐ **KAISER PERMANENTE (HMO)** *(Plan 767, EU 0 thru 7)*
- ☐ $10 COPAY PLAN
- ☐ $10 COPAY PLAN PLUS DENTAL & HEARING AID
- ☐ $20 COPAY PLAN
- ☐ $20 COPAY PLAN PLUS DENTAL & HEARING AID

☐ **HEALTH NET**
- ☐ HMO

WASHINGTON
- ☐ KAISER PERMANENTE (HMO)

☐ **UNITED HEALTHCARE**
- ☐ HMO
- ☐ PPO

PERSONAL & DEPENDENT INFORMATION

FULL NAME	RELATION**	SEX	DATE OF BIRTH	SOCIAL SECURITY #	HMO PHYSICIAN/PMG#
PARTICIPANT					
SPOUSE					
DEPENDENT					
DEPENDENT					

****RELATION – SPOUSE, SON, DAUGHTER, STEPSON, STEPDAUGHTER, OTHER**

HEALTH MAINTENANCE ORGANIZATION (HMO) SERVICE AGREEMENT OR PREFERRED PROVIDER PLAN REGULATIONS, WHICHEVER APPLIES. I UNDERSTAND THAT THE SERVICE AGREEMENT PROVIDES THAT ALL CLAIMS, INCLUDING MEDICAL MALPRACTICE CLAIMS, WHICH ARISE BECAUSE I OR SOMEONE WITH A RELATIONSHIP TO ME, 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 ANY HARM, MUST BE SUBMITTED TO BINDING ARBITRATION INSTEAD OF COURT TRIAL.

SIGNATURE _____ **DATE** _____

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 _____ **DATE** _____

THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION

TRUST FUND USE ONLY		
PURCHASER ID	ENROLLMENT UNIT	EFFECTIVE DATE

**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.*

- ANY CHANGE IN PLAN WILL TAKE EFFECT ON THE FIRST OF THE MONTH FOLLOWING RECEIPT OF YOUR APPLICATION OR UPON MEETING THE ELIGIBILITY REQUIREMENTS FOR THAT PLAN.

- MEDICARE SUPPLEMENTAL FORMS ARE REQUIRED FOR ALL MEMBERS ENROLLING IN MEDICARE PLANS. PLEASE CONTACT THE TRUST FUND ADMINISTRATION OFFICE AT THE NUMBER LISTED ABOVE SHOULD YOU REQUIRE COPIES OF THESE FORMS. YOU MUST REMAIN ENROLLED IN MEDICARE PARTS A AND B IN ORDER TO REMAIN ELIGIBLE FOR MEDICARE SUPPLEMENT PLANS.

- IT IS YOUR RESPONSIBILITY TO NOTIFY THE FUND SHOULD THE ENROLLMENT OR MEDICARE STATUS OF ANY MEMBER OF YOUR PLAN CHANGE.

SIGN UP TODAY TO HAVE YOUR RETIREE SELF-PAYMENTS MADE BY AUTOMATIC PAYMENT!

THE BOARD OF TRUSTEES OF THE CMTA-IAM JOINT RETIREE HEALTH & WELFARE PLAN IS PLEASED TO ANNOUNCE THAT YOU CAN NOW SIGN UP TO HAVE YOUR MONTHLY RETIREE SELF-PAYMENTS MADE BY AUTOMATIC PAYMENT FROM YOUR CHECKING OR SAVINGS ACCOUNT.

THE BENEFITS OF AUTOMATIC PAYMENTS AND "HOW TO SIGN UP" ARE SHOWN BELOW AND CONTACT THE TRUST FUND OFFICE FOR THE AUTHORIZATION FOR.

THE AUTOMATIC PAYMENT BENEFITS ARE:

- RELIABLE, SECURE, ACCURATE AND CONFIDENTIAL.
- QUICK AND EASY TO SET UP WITH NO ADDITIONAL COST TO YOU.
- YOU NEVER NEED TO WORRY ABOUT YOUR RETIREE HEALTH CARE COVERAGE LAPSING DUE TO LATE OR NON-PAYMENT.
- NO MORE MONTHLY COUPONS AND NO POSTAGE COSTS.

GETTING STARTED:

- COMPLETE THE AUTHORIZATION FORM ON THE REVERSE SIDE.
- RETURN COMPLETED AUTHORIZATION FORM TO THE CMTA-IAM JOINT RETIREE H&W TRUST FUND OFFICE
- IF YOU SELECT A CHECKING ACCOUNT FOR YOUR AUTOMATIC PAYMENT, ENCLOSE A VOIDED CHECK ALONG WITH THE SIGNED AUTHORIZATION FORM.

WHEN WILL IT BECOME EFFECTIVE?

- THERE IS UP TO A 60-DAY PROCESSING TIME TO IMPLEMENT AUTOMATIC PAYMENTS. THE TRUST FUND OFFICE WILL ACKNOWLEDGE RECEIPT OF YOUR AUTHORIZATION FORM, CONFIRM THE DEBIT AMOUNT AND THE FIRST AUTOMATIC PAYMENT TRANSACTION DATE FOR YOUR RECORDS.

CAN I ELECT THIS AUTOMATIC PAYMENT AT A LATER DATE?

- YES! IF YOU DO NOT ELECT THE AUTOMATIC PAYMENT OPTION AT THIS TIME, YOU CAN SUBMIT THE FORM AT A LATER DATE. IF YOU NEED A NEW FORM, PLEASE CONTACT THE TRUST FUND OFFICE AND A NEW ONE WILL BE SENT TO YOU.

QUESTIONS?

THE BILLING AND ELIGIBILITY PARTICIPANT ASSISTANCE UNIT AT THE TRUST FUND OFFICE IS AVAILABLE TO ASSIST YOU. THE LOCAL AND TOLL-FREE TELEPHONE NUMBERS ARE SHOWN ABOVE.