

# NORTHERN CALIFORNIA UFCW WHOLESALE HEALTH & WELFARE FUND

C/O UFCW & EMPLOYERS TRUST, LLC  
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## RETIREE ENROLLMENT FORM

**COMPLETE ALL INFORMATION – PLEASE PRINT IN BLACK OR BLUE PERMANENT INK**

PARTICIPANT DATA						
LAST NAME	FIRST NAME	INT.	SOCIAL SECURITY NUMBER			
MAILING ADDRESS (STREET OR P. O. BOX)			SEX	DATE OF BIRTH	UNION LOCAL	
MAILING ADDRESS LINE 2			E-MAIL ADDRESS			
CITY	STATE	ZIP	TELEPHONE NUMBER (    )			
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DOMESTIC PARTNER	DATE OF MARRIAGE/DIVORCE	ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B? <input type="checkbox"/> YES – EFFECTIVE DATE _____ <input type="checkbox"/> NO				
<b>MEDICAL SELECTION-NON-MEDICARE – CHOOSE ONE</b>						
<input type="checkbox"/> KAISER (HMO DEDUCT) GROUP# _____ EU _____			<input type="checkbox"/> BLUE SHIELD (HMO DEDUCT) GROUP# _____ EU _____			
<b>MEDICAL SELECTION MEDICARE ELIGIBLE – CHOOSE ONE</b>						
<input type="checkbox"/> BLUE SHIELD MEDICARE SUPPLEMENT GROUP# _____ EU _____		<input type="checkbox"/> KAISER – SENIOR ADVANTAGE GROUP# _____ EU _____			<input type="checkbox"/> UNITED HEALTH CARE SENIORITY GROUP# _____ <input type="checkbox"/> HEALTH NET – SENIORITY PLUS GROUP# _____ <input type="checkbox"/> HEALTH NET MEDICARE SUPPLEMENT GROUP# _____	
<b>DENTAL SELECTION - (CHOOSE ONE <u>ONLY</u> IF YOUR BENEFITS INCLUDE DENTAL COVERAGE)</b>						
<input type="checkbox"/> DELTA PPO DENTAL GRP# 2455-0002 <input type="checkbox"/> NEWPORT DENTAL (BRIGHT NOW!) GRP# NP3083			<input type="checkbox"/> DELTA CARE (PMI) GRP #05145-001 <input type="checkbox"/> UHC DENTAL HMO GRP #			
FAMILY DATA						
RELATION*	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY #	HMO PCP & PPG # OF KAISER MEDICAL RECORD NO.
Participant						
Spouse/Domestic Partner						
Dependent*						
Dependent*						
Dependent*						
<b>**Relation – Spouse, Son, Daughter, Step-son, Step-daughter, Other – See dependent on reverse side</b>						

**Important Notice:** I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the 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, believe 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.

**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 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 or 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.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities. Health Net Entities may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the web site at [www.healthnet.com](http://www.healthnet.com) or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 30 months from the date of my signature below. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**ACKNOWLEDGEMENT AND AGREEMENT:** I understand and agree that by enrolling with or accepting services from the Health Net Entities, the SafeGuard Entities and/or the Fidelity Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract of Insurance Policy. I have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

**BINDING ARBITRATION AGREEMENT:** Subject to their terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the applicant understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding construction, interpretations, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to have their disputes decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration and binding arbitration. A more detailed arbitration provisions is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**Northern California UFCW Wholesale Health And Welfare Fund**

**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 you will not be permitted to change your Plan until the next annual open enrollment period, which is during the month of May each year (changes effective August 1<sup>st</sup>).

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

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

**DEPENDENT ELIGIBILITY AND ENROLLMENT – WHO IS ELIGIBLE**

**If YOU qualify for benefits, the following dependents may be covered:**

- **YOUR LEGAL SPOUSE**
- **UNMARRIED CHILDREN** who are less than 21 years of age. Eligible children must be 14 days of age for Life Insurance coverage. The definition of unmarried children are those declared by you as dependents for Federal Income Tax purposes and include your:
  - NATURAL CHILDREN
  - STEP-CHILDREN
  - LEGALLY ADOPTED CHILDREN
  - CHILDREN PLACED FOR ADOPTION
  - CHILDREN FOR WHOM YOU HAVE BEEN LEGALLY APPOINTED GUARDIAN.
- **DEPENDENTS ENROLLED AND RECORDED AS FULL-TIME STUDENTS** (as defined by the Institution) at a recognized educational institution will have eligibility extended to age 23. Evidence required for continued eligibility.
- **DISABLED DEPENDENT CHILDREN** over age 21 and incapable of self-supporting employment because of mental retardation or physical handicap will have eligibility extended. Evidence must be submitted at attaining age of 21. Refer to special rules and regulations in Summary Plan Description.

**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.**

The Enrollment Form requires that you name a beneficiary to your Death and Accidental Death & Dismemberment Benefits under the Fund. Be sure to complete it and be specific as to whom you are naming – give full name with Jr., Sr. etc. to avoid confusion with anyone else.

<b>BENEFICIARY OF DEATH BENEFIT</b>			
BENEFICIARY'S FULL NAME & ADDRESS	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #

**YOU MUST SIGN BELOW TO AUTHORIZE THE BENEFICIARY DESIGNATIONS**

\_\_\_\_\_  
**YOUR SIGNATURE**

\_\_\_\_\_  
**DATE**