TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND

Enrollment Form
Actives & Non-Medicare Retirees

INSTRUCTIONS: Complete EACH section front and back. SIGN and DATE.
Use INK. PRINT.
For questions, call (877) 214-8928.

MAIL TO: Northwest Administrators, Inc.
225 South Lake Avenue, Suite 110
Pasadena, CA 91101
www.nwadmin.com

ADMINISTRATIVE USE ONLY			
☐ **Composite Plan**	☐ **3 Tier Plan**: ☐Single ☐Two-Party ☐Family	☐ **4 Tier Plan**: ☐EE ☐EE+Sp ☐EE+Child(ren) ☐Family	
Group No.:	**Effective Date of Coverage:**	**Clerk:**	**Date:**

PLEASE CHECK ALL THAT APPLY:	**TYPE OF CHANGE – CURRENT TRUST PARTICIPANT:**		
☐New Hire	☐Name	☐Plan	☐Rehire Date:_____
☐Open Enrollment	☐Address	☐Marital Status	☐PT to FT Employment Date: _____
☐Current Trust Participant	☐Add/Delete Dependent(s)	☐Coordination of Benefits (COB)	☐Other:_____

SECTION I – EMPLOYEE INFORMATION

Last Name	**First Name**	**M.I.**	**Social Security Number**

Mailing Address	**Gender** ☐M ☐F	**Date of Birth (MM/DD/YYYY)**

City	**State**	**Zip**	**Marital Status** ☐Single	☐Married Date:_____	☐Divorced Date:_____	☐Widow Date:_____

Home Telephone Number	**Mobile Telephone Number**	**Email Address**

Employer	**Date of Hire**	**Local Union Number**
PSUSD		911

CHOICE OF MEDICAL PLANS (Actives/Non-Medicare Retirees only):
(contact the carrier for HMO Provider selection)
☐Anthem Blue Cross Medical Reimbursement Plan (PPO)
☐Anthem Blue Cross HMO (**signature required on pg. 4**)
☐~~Anthem Blue Cross SIMNSA (**signature required on pg. 4**)~~
☐Kaiser Permanente HMO (**signature required on pg. 3**)

~~**CHOICE OF DENTAL PLANS** (if applicable):~~
~~*(contact the carrier for HMO Provider selection)*~~
~~**LIBERTY Dental Plan**~~
☐~~PPO~~
☐~~DHMO~~
☐~~I do not wish to enroll in Dental Coverage~~

SECTION II – DEPENDENT INFORMATION

(Additional dependents may be listed on a separate sheet. Please ensure all required dependent information/documents are provided.)

Relation	**Add / Delete**	**Last Name**	**First Name**	**Gender**	**Date of Birth**	**Social Security No./TIN**	**If children are age 26 or over you must check the appropriate box below**	**Indicate if this coverage is primary**
☐**Spouse** ☐**Domestic Partner**	☐ **Add** ☐**Delete**			☐M ☐F			**IRS Qualified Dependent**	☐**Yes** ☐**No**
Dependent	☐ **Add** ☐**Delete**			☐M ☐F			☐**Yes** ☐**No**	☐**Yes** ☐**No**
Dependent	☐ **Add** ☐**Delete**			☐M ☐F			☐**Yes** ☐**No**	☐**Yes** ☐**No**
Dependent	☐ **Add** ☐**Delete**			☐M ☐F			☐**Yes** ☐**No**	☐**Yes** ☐**No**
Dependent	☐ **Add** ☐**Delete**			☐M ☐F			☐**Yes** ☐**No**	☐**Yes** ☐**No**

SECTION III – OTHER INSURANCE INFORMATION

(Please complete this section below if you or a dependent have other insurance coverage)

Name of Insured Person:	Insurance Company Name:
Insurance Company Address:	Telephone #:
Effective Date of Coverage:	Policy #:
Name of Insured Person:	Insurance Company Name:
Insurance Company Address:	Telephone #:
Effective Date of Coverage:	Policy #:
Name of Insured Person:	Insurance Company Name:
Insurance Company Address:	Telephone #:
Effective Date of Coverage:	Policy #:

SECTION IV – MEDICARE

(Please complete the section below and enclose a copy of Medicare card if you or a dependent are enrolled in Medicare)

Name of Individual receiving Medicare:	Receiving Part A? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____
	Receiving Part B? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____
Name of Individual receiving Medicare:	Receiving Part A? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____
	Receiving Part B? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____
Name of Individual receiving Medicare:	Receiving Part A? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____
	Receiving Part B? ☐Yes ☐No If Yes, Effective Date: _____/_____/_____

It is a crime to knowingly provide false, incomplete or misleading information to the Trust Administrative Office for the purpose of defrauding the Trust. With my signature, I hereby certify that the information provided in this enrollment form is true and correct.

SIGNATURE OF PARTICIPANT: ____ **DATE**: _______/______/_______

THIS FORM MUST BE SIGNED AND DATED TO PROCESS YOUR ENROLLMENT

INSTRUCTIONS: (Please read carefully before completing the Enrollment Form)
The Enrollment Form must be completed in order to enroll you and your dependents. Be sure to complete all of the information requested. Under the terms of your coverage, you may make an election of the Medical and Dental Plans. Be sure to complete the section title "Choice of Medical Plans" and "Choice of Dental Plans".

Reminder: Changes to your medical election coverage are only permitted once in a 12 month period, during the Fund's Open Enrollment. Changes to your dental election coverage will be in effect for 12 months. You will be unable to make any changes until the next reenrollment period which is 12 months from the effective date of this dental benefit plan change. The change in your dental plan will be effective the 1st day of the month following receipt of this form provided it is received on or before the 20th day of the month. If this form is received after the 20th day of the month, your dental plan change will be effective the 1st of the following second month. Please note, you have the option of opting out of your dental coverage. Opting out of dental coverage does not eliminate or reduce any payroll deduction or self-pay cost to you nor any contribution cost to your employer. If you are considering this, you should contact the Administrative Office immediately. If you select this option, a representative from the Administrative Office will contact you.

RETIREES: YOU MUST ENROLL FOR RETIREE COVERAGE UNDER THE FUND WITHIN 12 MONTHS OF YOUR RETIREMENT DATE OR THE LAST MONTH FOR WHICH A CONTRIBUTION WAS MADE ON YOUR BEHALF BY YOUR LAST EMPLOYER.

TO ADD OR CHANGE YOUR DEPENDENTS, THE FOLLOWING DOCUMENTATION IS REQUIRED:

- Copies of certified Marriage Certificate issued by the Hall of Records if adding a Spouse.
- Copies of the certified Birth Certificates issued by the Hall of Records if adding dependent children.
- Foster & Adopted children: Legal guardianship or court adoption papers.

DEFINITION OF ELIGIBLE DEPENDENTS:

- Your legal spouse (if not legally separated)
- Eligible children dependents include your natural children, step children, legally adopted children (or children placed for adoption), children for whom you have legal guardianship, and children for whom you are responsible pursuant to a Qualified Medical Child Support Order.
- Your children who are incapable of self-support because of mental or physical incapacities **prior** to reaching age 26.
- Qualified Domestic Partner – must apply and qualify separately for Domestic Partner coverage through the Administrative Office.

Kaiser Foundation Health Plan 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 OF PARTICIPANT (Required if electing Kaiser): _____ **DATE**: _____/_____/_____

Anthem Blue Cross Health Plan Arbitration Language
PLEASE READ CAREFULLY – SIGNATURE REQUIRED
I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.
DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.
NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.
HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.
EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE
You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3)

paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice.

If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end.

If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

As part of the W–9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

SIGNATURE OF PARTICIPANT (Required for Anthem Enrollees): _____ DATE: _____/_____/_____