English

Southern California Painting and Drywall Industry Health & Welfare Plan

PO Box 5548 • El Monte, CA 91734-1548 • 4399 Santa Anita Avenue, Suite 150 • El Monte, CA 91731
T 626.279.3020 • 1.800.752.2394 • F 626.279.3055

Participant's Agreement

Enrollment/Change Form Instructions

1 Member's Personal Information

- Member must complete information requested. If selecting Kaiser Permanente please make sure to sign the Kaiser Permanente Arbitration Agreement on this form or your form will be returned.

2 Dependent Information

- List family members to be covered. If additional lines are needed, you may complete an additional Enrollment/ Change Form.
- Provide proof of relationship.
  - Newborn dependents must be enrolled within 30 days.
  - Original Certificate of Marriage of your spouse and original Certificate of Birth of each dependent will be required to establish eligibility. Photocopies will not be accepted.
  - Effective January 1, 2011, dependent children up to twenty-six (26) years of age will be eligible for continued coverage.
- Dependent's Social Security Numbers are required for CMS & IRS reporting.

3 Coordination of Benefits

- If you or any of your dependents are receiving other coverage, please provide information requested.
- Provide new Medicare required information. Failure to provide this information may delay eligibility.
- Provide your Health Insurance Claim Number (HICN) or Medicare Number if you are receiving Medicare Part A or B or have received a Kidney Transplant or are on Dialysis.

4 Designation of Beneficiary(ies)

- By completing this section, Member is requesting that any benefits becoming payable by reason of your death shall be payable to your designated beneficiary(ies).
- The Designation of Beneficiary(ies) is subject to all respective rules of the Health and Welfare Plan.
  - You must obtain your spouse's written consent to designate a beneficiary other than your spouse.
- Member should keep a record of the designated beneficiary(ies).The Trust Fund may be obligated to provide benefits to your last designated beneficiary(ies) even when you may have had other intentions before your death.

5 Medical Plan Coverage Election

- Member must elect one medical plan.
  - If no medical plan is elected, member and all dependents enrolled on your Enrollment/Change Form will be enrolled in the Southern California Painting and Drywall Industry PPO Plan under Level C.
    If you are a Retired participant, you may not enroll in the PPO plan unless you live outside the HMO service area.

6 Dental Plan Coverage Election

- Member must elect one dental plan.
  - If no dental plan is elected, member and all dependents enrolled on your Enrollment/Change Form will not be enrolled in any dental plan.
  - Plan Level B participants have the Delta Care USA Dental Plan option only.

7 Member's Signature

(Please read carefully before signing)

- Member must complete form, sign and date the Enrollment/ Change Form.

Completion of your Enrollment/Change Form means that you are stating all information provided in sections 1 through 6 are true, correct and current; and that you have read and agree with, as well as agree to comply with the following terms and conditions:

- Review your available plans and options.
- Select the benefit plan options most appropriate to you or your dependents.
- Submit supporting, original documentation, such as the original Certificates of Marriage and Birth to the Trust Fund Office if enrolling dependents for the first time. (Without the supporting, original documentation, your Enrollment/ Change Form may not be processed.)
  - I agree to promptly furnish such proof to the Board of Trustees and further agree to the preconditions for payment of any benefits for me or on behalf of my dependents.
  - Provide social security numbers for all of your dependents in order for them to be eligible for benefits, as required by federal law.
  - Provide additional information about any other group health plan coverage in Section 3, as required by federal law.
  - On behalf of myself and my eligible Dependents, I hereby apply for Health Welfare care for medical and dental services coverage offered through the Southern California Painting and Drywall Industry Health & Welfare Plan, I understand, agree with as well as agree to comply with the terms and conditions below.
  - I authorize the Welfare Plan or its representatives or designees to access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or health care operations of the Agreement or Policy.

Member's Signature (required)

X _____

Date_____

Southern California Painting and Drywall Industry Health & Welfare Plan

ACTIVE/RETIREES

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Q R / Q R 2 G E

Enrollment/Change Form

ACTION (Check all that apply)
*Include Supporting Documents

ENROLLMENT REASON: New Hire ☐ Open Enrollment ☐ Other _____

*NEW ENROLLMENT ☐ Date of Hire _____

CHANGE - ADDRESS ☐ BENEFICIARY ☐ *ADD DEPENDENT ☐

*DELETE DEPENDENT ☐ Due to Death ☐ *MARITAL STATUS ☐ PLAN ☐

Effective Date of Coverage _____

Event Date (mm/dd/yyyy) _____ (date of qualified event such as loss of coverage, marriage, divorce, etc.)

SECTION 1 – MEMBER INFORMATION ☐ ACTIVE ☐ RETIREE

Member's Last Name	First Name	Middle Initial

Social Security Number	Gender	Birth Date (mm/dd/yyyy)	Preferred Language
– –	☐ Male ☐ Female	/ /	☐ English ☐ Spanish ☐ Other _____

Street Address	City	State	Zip Code

Home Phone	Cell Phone	E-mail Address
( )	Text? ☐ Yes ☐ No ( )	

Marital Status	Provide your Primary Care's Office ID #	Local Union No.	Retirement Date (mm/dd/yyyy)	Plan Level
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed				☐ A ☐ B ☐ C

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective Date _____ (Submit a copy of your Medicare card) Part B ☐ Effective Date _____	Kidney Transplant? ☐ Yes ☐ No Date of Transplant _____
Health Insurance Claim Number (HICN) or Medicare Number _____	Dialysis? ☐ Yes ☐ No Date of Dialysis _____

SECTION 2 – DEPENDENT INFORMATION List spouse and eligible dependents who will be covered under the Plan.

If you are electing Aetna, please provide your Primary Care's Office ID Number in the space below for each dependent.
(If you have more than 4 dependents, please complete an additional Enrollment Form)

1

Spouse's Last Name	First Name	Middle Initial	Social Security Number
			– –

Birth Date (mm/dd/yyyy)	Gender	Marriage Date (mm/dd/yyyy)	Domestic Partner Role
/ /	☐ Male ☐ Female	/ /	☐ Spouse ☐ Domestic Partner

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective Date _____ (Submit a copy of your Medicare card) Part B ☐ Effective Date _____	Kidney Transplant? ☐ Yes ☐ No Date of Transplant _____	
Health Insurance Claim Number (HICN) or Medicare Number: _____	Dialysis? ☐ Yes ☐ No Date of Dialysis _____	

2

Dependent's Last Name	First Name	Middle Initial	Social Security Number
			– –

Birth Date (mm/dd/yyyy)	Gender	
/ /	☐ Male ☐ Female	☐ Newborn Child ☐ Adoption/Legal Custody Child Date _____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective date _____ (Submit a copy of your Medicare card) Part B ☐ Effective date _____	Kidney Transplant? ☐ Yes ☐ No Date of Transplant _____	
Health Insurance Claim Number (HICN) or Medicare Number: _____	Dialysis ☐ Yes ☐ No Date of Dialysis _____	

SECTION 2 – DEPENDENT INFORMATION (continued)

3

Dependent's Last Name	First Name	Middle Initial	Social Security Number
			– –

Birth Date (mm/dd/yyyy)	Gender	Newborn Child / Adoption/Legal Custody Child
/ /	☐ Male ☐ Female	Date_____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective date _____ (Submit a copy of your Medicare card) Part B ☐ Effective date _____	Kidney Transplant? ☐ Yes ☐ No Date of Transplant _____	
Health Insurance Claim Number (HICN) or Medicare Number: _____	Dialysis? ☐ Yes ☐ No Date of Dialysis _____	

4

Dependent's Last Name	First Name	Middle Initial	Social Security Number
			– –

Birth Date (mm/dd/yyyy)	Gender	Newborn Child / Adoption/Legal Custody Child
/ /	☐ Male ☐ Female	Date_____

If you are receiving Medicare, check all boxes that apply below:	Check all boxes that apply below:	Provide your Primary Care's Office ID Number
Receiving Medicare? ☐ Yes ☐ No Part A ☐ Effective date _____ (Submit a copy of your Medicare card) Part B ☐ Effective date _____	Kidney Transplant? ☐ Yes ☐ No Date of Transplant _____	
Health Insurance Claim Number (HICN) or Medicare Number: _____	Dialysis? ☐ Yes ☐ No Date of Dialysis _____	

SECTION 3 – COORDINATION OF BENEFITS

If you or your spouse, or any dependents are covered by Medicare or any other Group insurance policy providing medical benefits, please complete this section.

Where are your claims sent?	Company Name	Company Address (City, State, Zip Code)	Telephone ( )
Policy Holder Information	Name of Policy Holder	Employer	Policy Effective Date (mm/dd/yyyy) / /
	Family Member(s) Covered (1) (2) (3) (4)		
Reason for Medicare	Health Insurance Claim Number (HICN) or Medicare Number:_____ ☐ End Stage Renal Disease ☐ Disabled ☐ Over 65		Medicare Effective Date (mm/dd/yyyy) / /

SECTION 4 – DESIGNATION OF BENEFICIARY(IES) [for Health and Welfare Benefits]

I request that any benefits becoming payable by reason of my death be payable to the following beneficiary(ies).
I understand that this Designation of Beneficiary is subject to all respective rules of the Health and Welfare Plan.

1

Last Name	First Name	Middle Initial	Social Security Number
			– –

Address (City, State, Zip Code)	Relationship

2

Last Name	First Name	Middle Initial	Social Security Number
			– –

Address (City, State, Zip Code)	Relationship

Member's Signature X _____ **Date**_____

Signature & Date Required

SECTION 5 – MEDICAL PLAN COVERAGE SECTION

Elect one Medical Plan. New participants who do no select a Medical Plan will be defaulted into the Indemnity PPO Plan.

✓ (Elect) One Medical Plan Below	Medical Plan Options	Benefits Administered by	Comments	Binding Arbitration Required
	Kaiser Permanente (HMO)	Kaiser Foundation Health Plan	Provide your Kaiser Permanente Medical Record Number _____ Kaiser Permanente Purchaser I.D. Number 100253 Enrollment Unit _____	Yes

Electing Kaiser Permanente (HMO Plan – Group 100253)

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.

Member's Signature X _____ **Date**_____

Signature Required for Kaiser Permanente HMO Plan

	Aetna (HMO Group Number 849895	Aetna Health of California, Inc.	Preferred Language to Communicate if other than English Are you a current patient? Member Yes _ No ¯ Spouse Yes No ⌈ (D= Dependent) D2 Y ¯ N ⌈ D3 Y ⌈ N ¯ D4 Y ⌈ N ⌈	Yes

Electing Aetna (HMO Plan – Group 849895)

Aetna Health of California Inc Arbitration Agreement:

Any dispute arising from or related to Health Plan membership may be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by this Agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. The Health Plan agreement also limits certain remedies and may limit the award of unitive damages. See the Evidence of Coverage for further information. I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the Health Plan agreement contains limitations on certain remedies and that there may br certain limitations to the recovery of punitive damages.

Member's Signature X _____ **Date**_____

Signature Required for Aetna HMO Plan

	Indemnity PPO Medical Plan	SCPDI H&W Plan Trust Fund	Southern California Painting and Drywall Industry Health & Welfare Plan's PPO Plan uses the Anthem Blue Cross Prudent Buyer Plan, a PPO network.	Yes

Electing Painters' Indemnity (PPO Plan – Group 276442M001)

Painters Indemnity Self-Funded Plan Arbitration Agreement:

The Plan uses the Anthem Blue Cross Prudent Buyer Plan, a PPO network. I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider.

I agree to promptly reimburse the Trust Fund in full for any monies paid if the Trust Fund pays benefits for or on behalf of me or of any person listed as a dependent on my Enrollment/Change Form when I am or such person is not, in fact, eligible to the benefits or if the Trust Fund otherwise mistakenly pays benefits. I also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from my future benefits. I agree to pay all attorney fees and any cost of the Trust Fund, whether or not such an action proceeds to judgment if the Trust Fund files any legal action against me to recover any such monies, whether or not such an action proceeds to judgment. The Trustees reserve the right to change, add or eliminate benefits at any time.

Member's Signature X _____ **Date**_____

Signature Required for Indemnity PPO Plan

SECTION 6 – DENTAL PLAN COVERAGE SECTION

Elect one Dental Plan. Please contact the Trust Fund Office if you would like a complete copy of the Delta Dental *Evidence of Coverage* (EOC) and Disclosure Form.

✓ **(Elect) One** Dental Plan Below	Plan Options	Benefits Administered by	Comments
	DeltaCare USA Group 71016-0001	Delta HMO	Indicate your Dentist/Provider Number _____
	Delta Dental of CA Delta Preferred Option (PPO) Plan (Read comments)	PPO	Plan Level A - Group 10663-00002

Electing DeltaCare USA Plan (PPO Plan – Group 71016-0001) or Delta Dental of California Delta Preferred Option Plan (PPO Plan Level A – Group 10663-00002)

Delta Dental Disclosure (Refer to the complete Combined Evidence of Coverage and Disclosure Form from Delta Dental for more details.)

You must select a provider from the network listing and indicate that on your Enrollment/Change Form. You may elect to change providers within the network by contacting DeltaCare's Customer Service Department at 1.800.422.4234.

Delta Dental's co-payment for your benefits is shown in the Evidence of Coverage under the caption titled "YOUR BENEFITS." If dental services are provided by a Delta Dental Dentist or a Delta Dental DPO Dentist, you are responsible for the co-payment only. If the dental services you receive are provided by a dentist who is not a Delta Dental Dentist or Delta Dental DPO Dentist, you are responsible for the difference between the amount Delta Dental pays and the amount charged by the non-Delta Dental dentist.

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330.

Member's Signature X _____ **Date**_____

Signature Required for DeltaCare USA Plan or Delta Dental of California Plan

Plan Level Banking Option

If you establish eligibility and do not make a Plan Level Selection, you will be enrolled in Level C and will bank at Level C until you select a different Plan Level.

To sign up for the benefit Plan Level (A, B or C) It is important that you provide your selection in Section 1 on the Enrollment/Change Form.

Benefit Plan Level	Minimum Credits Required Monthly For Eligibility	Description of Plans
Level A	1,183 or more contribution credits	Provides most coverage
Level B	1,014 or more contribution credits	Same Level A covered benefits with higher co-payment
Level C	845 or more contribution credits	No dental or vision benefits with higher co-payment