

Laborers Health and Welfare Trust Fund for Southern California

1123 Park View Dr., Suite 200 • Covina, CA 91724
P.O. Box 3389 • Covina, CA 91722-5389
T (626) 279-3000 • 1(800) 887-5679 • F (626) 279-3094
www.socalaborers.org

Active Member

Enrollment/Change Form Instructions



- The number in each circle below represents the section on the enrollment form.
- These instructions are intended to help you complete your Enrollment/Change Form.

1 Member's /Employee's Information

- Member/Employee must complete information requested.
- If you are eligible for Medicare Part A or B, or have had a kidney transplant or are on kidney dialysis, provide Health Insurance Claim Number (HICN) and applicable information. Failure to provide this information may delay eligibility.

2 Dependent's Information

- List family members eligible to be covered in Section 2. If additional lines are needed, you may complete an additional Enrollment/Change Form.
- Newborn dependents must be enrolled within 30 days of birth.
- Provide proof of relationship for each dependent you are enrolling: Original Certificate of Marriage for Spouse and Certificate of Birth of each dependent will be required to establish eligibility. (Photocopies will not be accepted.)
- Dependent Children up to age 26 are eligible to be covered by the Plan and if not enrolled in this Plan, you may now elect coverage for your eligible dependent children.
- Totally and permanently disabled children may be eligible for continued coverage over age 26, as determined under the terms of the applicable benefit program.
- If you have coverage with Medicare, Medi-Cal, or have other medical insurance, you must provide the information so benefits may be coordinated.
- Provide your Health Insurance Claim Number (HICN) if you are receiving Medicare Part A or B or have received a Kidney Transplant or are on Dialysis. Failure to provide this information may delay eligibility.
- Provide social security numbers for dependents, as they are required for CMS and IRS reporting.

3 Life Insurance Designation of Beneficiary(ies)

- Provide information of beneficiary(ies) you would like to designate to receive any benefits in case of your death.
- Your signature and date signed are required.

4 Medical Plan Coverage Selection

- If you are selecting a medical plan for the first time, you should expect to participate in that medical plan for a minimum of 12 months before making another plan change.
- Review and compare each plan's coverage you are being offered in the Summary of Benefits booklet before making your medical plan selection.
- Make your plan selection by checking the appropriate plan's box; complete any information required; and read the plan's agreement. If no selection is made, you will be enrolled in the Laborers' PPO Medical Plan.
- Member/Employee must sign and date the plan's agreement.

5 Dental Plan Coverage Selection

- If you are selecting a dental plan for the first time, you should expect to participate in that medical plan for a minimum of 12 months before making another plan change.
- Review and compare each plan's coverage you are being offered in the Summary of Benefits booklet before making your dental plan selection.
- Make your plan selection by checking the appropriate plan's box; complete any information required; and read the plan's agreement. If no selection is made, you will be enrolled in the Laborers' PPO Dental Plan.
- Member/Employee must sign and date the plan's agreement.

6 Vision Benefits

- If you are eligible for vision coverage, your coverage is provided by Anthem Blue View Vision. Information about your coverage is in your Summary of Benefits booklet.

Prescription Drug Coverage

- Your prescription coverage is provided by Optum Rx if enrolled in the Laborers EPO or PPO medical plans. If enrolled in an HMO medical plan, your prescription coverage is through the HMO. Additional information about your coverage is available in the Summary of Benefits Booklet.

Hearing Aid Coverage

- Hearing Aid coverage is through EPIC Hearing Healthcare. Additional information about your coverage is available in the Summary of Benefits Booklet.

**To view your eligibility and claims, and to access benefit information and forms, please visit our website at:
www.socalaborers.org**



**Please keep a copy of the
Instructions for your
reference.**

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TRUST FUND USE ONLY

Effective Enrollment/Change Date _____

_____ Kaiser Permanente - 115155 - _____

_____ EPO/PPO Plan - 276444 _____

_____ SIMNSA Plan - 244

_____ Delta Dental - 05419 _____

Active Member Enrollment/Change Form

SECTION 1 - TO BE COMPLETED BY EMPLOYEE

Your preferred language is English Spanish

Employer Name:

Job Title:

Hire Date:

Employee, please provide your information in each column below

When making a Plan Change, you must have participated in your current plan for 12 months. Check all actions applicable and provide the effective date of the change/request and the supporting document. If already enrolled in a plan and making a change from your last enrollment, please remember to check the Arbitration Agreement for each (medical and/or dental) Plan, then read and sign the Plan's arbitration's signature line.

Member's Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)	Social Security Number
Mailing Address				Local Union
City		State	Zip Code	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone (H)	Cell Phone (C)	Work Phone (W)	Email Address	

The best method to contact you is by: Standard Mail H C W Phone Email

Marital Status: Single Married Separated Divorced Widowed

Are you receiving Medicare? No Yes
 Part A Effective Date: _____; Part B Effective Date: _____

Dialysis? Yes No
 Effective Date of Dialysis:

(If yes, a copy of your Medicare card must be submitted)

Health Insurance Claim Number (HICN) or Medicare Number: _____
 Reason for Disability if Under Age 65 _____

Kidney Transplant? Yes No
 Effective Date of Transplant:

<input checked="" type="checkbox"/>	Reason for Election - Check all that apply and provide effective date	<input checked="" type="checkbox"/>	Add/Change - Check all that apply and provide effective date*
<input type="checkbox"/>	Enrollment Reason: Provide the date: _____ and check reason below: <input type="checkbox"/> New Hire <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Other Coverage (Explain): _____	<input type="checkbox"/>	<input type="checkbox"/> Add Spouse/Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> 12-Month Plan Change <input type="checkbox"/> Address Change <input type="checkbox"/> Marital Status Change <input type="checkbox"/> Other: _____ <input type="checkbox"/> Effective Date: _____ <i>*If no effective date provided, requests received on or after the 15th day of the month, will be made effective on the 1st day of the month following receipt.</i>



SECTION 2 - DEPENDENT INFORMATION List eligible spouse and dependent child(ren) who will be covered under the Plan.
(If you have more than three [3] dependent children, please complete an additional Enrollment Form.)

D1	Spouse's Last Name		First Name		Middle Initial	Social Security Number
	Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marriage Date (mm/dd/yyyy)	
	Are you receiving Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes				Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Part A <input type="checkbox"/> Effective Date: _____; Part B <input type="checkbox"/> Effective Date: _____ (If yes, a copy of your Medicare card must be submitted)				Effective Date of Dialysis: _____	
	Health Insurance Claim Number (HICN) or Medicare Number: _____				Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Reason for Disability if Under Age 65 _____				Effective Date of Transplant: _____	
	Are you covered or enrolled in another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide the information below.)					
Type of Coverage:			Where are your claims sent?		Name of Policy Holder	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Other: _____					Group/Policy Number	
Employer Name			Employer's Address (City, State, Zip Code)		Policy Effective Date	
D2	Dependent Child's Last Name		First Name		Middle Initial	Social Security Number
	Is mailing address different from the employee's or subscriber's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide address below.)					
	Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Physically or Mentally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you receiving Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes				Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Part A <input type="checkbox"/> Effective Date: _____; Part B <input type="checkbox"/> Effective Date: _____ (If yes, a copy of your Medicare card must be submitted)				Effective Date of Dialysis: _____	
	Health Insurance Claim Number (HICN) or Medicare Number: _____				Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Reason for Disability if Under Age 65 _____				Effective Date of Transplant: _____	
Are you covered or enrolled in another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide the information below.)						
Type of Coverage:			Where are your claims sent?		Name of Policy Holder	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Other: _____					Group/Policy Number	
Employer Name			Employer's Address (City, State, Zip Code)		Policy Effective Date	
D3	Dependent Child's Last Name		First Name		Middle Initial	Social Security Number
	Is mailing address different from the employee's or subscriber's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide address below.)					
	Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Physically or Mentally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Are you receiving Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes				Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Part A <input type="checkbox"/> Effective Date: _____; Part B <input type="checkbox"/> Effective Date: _____ (If yes, a copy of your Medicare card must be submitted)				Effective Date of Dialysis: _____	
	Health Insurance Claim Number (HICN) or Medicare Number: _____				Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Reason for Disability if Under Age 65 _____				Effective Date of Transplant: _____	
Are you covered or enrolled in another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide the information below.)						
Type of Coverage:			Where are your claims sent?		Name of Policy Holder	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Other: _____					Group/Policy Number	
Employer Name			Employer's Address (City, State, Zip Code)		Policy Effective Date	

SECTION 2 - DEPENDENT INFORMATION (Continued)

(If you have more than three [3] dependent children, please complete an additional Enrollment Form.)

D4	Dependent Child's Last Name	First Name	Middle Initial	Social Security Number
Is mailing address different from the employee's or subscriber's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide address below.)				
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Physically or Mentally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you receiving Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes Part A <input type="checkbox"/> Effective Date: _____; Part B <input type="checkbox"/> Effective Date: _____ (If yes, a copy of your Medicare card must be submitted)			Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Dialysis: _____	
Health Insurance Claim Number (HICN) or Medicare Number: _____ Reason for Disability if Under Age 65 _____			Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Transplant: _____	
Are you covered or enrolled in another group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, provide the information below.)				
Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Other: _____		Where are your claims sent?		Name of Policy Holder
				Group/Policy Number
Employer Name		Employer's Address (City, State, Zip Code)		Policy Effective Date

By signing below, I understand that I am enrolling dependents and this is subject to all respective rules of the Labors Health and Welfare Trust Fund for Southern California.

X _____
Signature of Member Required Date**SECTION 3 - DESIGNATION OF BENEFICIARY(IES). Life Insurance Benefit is through Aetna Life Insurance Company of Hartford.**

I request that any benefits becoming payable by reason of my death be payable to the following beneficiary(ies). Please provide information of each beneficiary below. If more rows are needed, you may complete an additional form.

1	Last Name	First Name	Middle Initial	Social Security Number	Percentage
	Address (City, State and Zip Code)				Relationship
2	Last Name	First Name	Middle Initial	Social Security Number	Percentage
	Address (City, State and Zip Code)				Relationship

By signing below, I understand that this Designation of Beneficiary is subject to all respective rules of the Laborers Health and Welfare Trust Fund for Southern California.

X _____
Signature of Member Required for Designation of Beneficiary Date**SECTION 4 - MEDICAL PLAN SELECTION**1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement.
3. (Member) Sign and date selected plan's signature box [✕].**Medical Plan Options (Choose one): SIMNSA • Kaiser Permanente • Laborers' EPO Plan • Laborers' PPO Plan** SIMNSA (HMO Plan) para familias de los empleados que viven en México - Todos los servicios deben ser proporcionados exclusivamente por los proveedores de SIMNSA en México. (Este Plan no es disponible para miembros jubilados.)**Al solicitar afiliación como miembro de Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA) para mi y miembros de mi familia que sean elegibles, acepto lo siguiente:**

- Todos los servicios deben ser proporcionados exclusivamente por los proveedores de SIMNSA, salvo emergencias (como explicado en los documentos de membresía).
- No deben de prestar su tarjeta de membresía a cualquier otra persona, por la cual quedara sujeto a cancelación inmediata y cargos penales.
- Estoy de acuerdo que SIMNSA obtendrá información médica acerca las personas que se incluyen en esta solicitud con el fin de administrar el Plan.
- Certifico que la información que incluyo en esta solicitud es verídica y correcta y que comprendo los beneficios y reglamentos de este Plan de Salud.
- Este plan usa el arbitraje atado exclusivamente para asentar toda disputa que surja bajo este acuerdo. Se entiende que cualquier disputa en cuanto a negligencia médica en caso de que algún servicio médico otorgado en California bajo este contrato era innecesario, no autorizado, inapropiado, negligente o incompetentemente otorgado, será determinado por la sumisión al arbitraje como es proporcionado por la ley de California, y no por un pleito o un proceso tribunal excepto como la ley de California estipula para la revisión jurídica de actos de arbitraje. Cualquier disputa que surja de servicios otorgados en México, la ley mexicana prevé revisión judicial de procedimientos arbitrales. Ambos partidos al aceptar este contrato renuncian a su derecho constitucional para tener cualquier disputa decidida en un tribunal de la ley ante un jurado, en lugar aceptan el uso de arbitraje. Para más información favor de referirse a su Constancia de Cobertura y Elegibilidad (CCE).

X _____
Firma del empleado es necesaria para el plan SIMNSA Fecha

SECTION 5 - MEDICAL PLAN SELECTION
(Continued)

1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement.
3. (Member) Sign and date selected plan's signature box [✕].

Kaiser Permanente (HMO) Plan (115155) if selecting Kaiser Permanente, please read the arbitration below before signing.

If you or your dependents were issued a Kaiser Permanente Medical Record Number, please write your number below

Medical Record Number Employee	Medical Record Number Dependent 1	Medical Record Number Dependent 2	Medical Record Number Dependent 3	Medical Record Number Dependent 4
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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 Required for all Kaiser Permanente Plans

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.*

Laborers EPO Plan

Participants in the Laborers EPO Plan must receive services from providers, and at laboratories and facilities participating in the Anthem Blue Cross Prudent Buyer (Prudent Buyer) network. Participants receiving services from non-participating providers, at non-participating laboratories or at non-participating facilities with the Prudent Buyer network will be responsible for any out-of-pocket expenses not covered by the Plan.

Laborers PPO Plan

Participants in the Laborers PPO Plan may receive less out-of-pocket expenses when receiving services from providers, at laboratories and facilities participating in Anthem Blue Cross' Prudent Buyer (Prudent Buyer) network.

Laborers Health Plan Agreement:

If the Trust Fund pays benefit for me or on behalf of me or any person listed as a dependent on this 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 agree to promptly reimburse the Trust Fund in full for any such monies paid. I also agree that the Trustees, in their sole discretion may deduct or offset any such monies, I agree to pay all attorney's fees and cost of the Trust Fund, whether or not such as an action proceeds to judgement.

The Trustees reserve the right to change, add or eliminate benefits at any time.

The Laborers EPO Plan uses the Anthem Blue Cross Prudent Buyer Plan (Prudent Buyer) network. I understand benefits will only be paid if I use participating providers, laboratories and facilities within the Plan's network. Exceptions may be considered in the event of an emergency. I understand when using Non-Participating Providers, Non-Participating Laboratories, or Non-Participating Facilities and Other Health Care Providers, I am responsible for any difference between the covered expense and actual charges, as well as any deductible and percentage copay.

The Laborers PPO Plan uses the Prudent Buyer network. I understand when using Non-Participating Providers, Non-Participating Laboratories or Non-Participating Facilities and other Health Care Providers, I am responsible for any difference between the covered expense and the actual charges, as well as any deductible and percentage copay. I also understand any preventive service received outside of the network will not be covered.

X _____

Signature Required for Laborers Health Plan

Date

SECTION 5 - DENTAL PLAN SELECTION

1. Select/Check the Plan's box. 2. Read the Plan's Arbitration Agreement.
3. (Member) Sign and date selected plan's signature box [X].

Dental Plan Options (Choose one): Laborers' PPO Dental Plan • DeltaCare, Delta Dental's (HMO) Plan

Laborers PPO Dental Plan (If selecting the PPO dental plan, your signature is required on the signature line for the Laborers PPO Dental Plan.)

Laborers Dental Plan Agreement:

If the Trust Fund pays benefit for me or on behalf of me or any person listed as a dependent on this 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 agree to promptly reimburse the Trust Fund in full for any such monies paid. I also agree that the Trustees, in their sole discretion may deduct or offset any such monies, I agree to pay all attorney's fees and cost of the Trust Fund, whether or not such as an action proceeds to judgement.

The Trustees reserve the right to change, add or eliminate benefits at any time.

The Laborers PPO Plan uses the Prudent Buyer network. I understand when using Non-Participating Providers, Non-Participating Laboratories or Non-Participating Facilities and other Health Care Providers, I am responsible for any difference between he covered expense and the actual charges, as well as any deductible and percentage copay. I also understand any preventive service received outside of the network will not be covered.

X _____ Date
Signature Required for Laborers PPO Dental Plan

DeltaCare, Delta Dental's (HMO) Plan (If selecting the HMO dental plan, your signature is required on the signature line for the DeltaCare, Delta Dental's (HMO) Plan below.)

	1 st Choice Dental Office	Address of Dental Office	2 nd Choice Dental Office	Address of Dental Office
Employee				
Spouse (D1)				
Child (D2)				
Child (D3)				
Child (D4)				

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 (new enrollees). You may elect to change providers within the network by contacting DeltaCare's Customer Service Department at 1 (800) 442-4234.

Delta Dental's co-payments for your benefits are shown in the DeltaCare USA Provided by Delta Dental of CA/Evidence of Coverage under caption titled "Highlights of your DeltaCare USA Program." If dental services are provided by a DeltaCare USA dentist, you are responsible for the co-payment only. If the dental services you receive are provided by a dentist who is not a DeltaCare USA dentist, you are responsible for the full cost of the treatment.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care (noted in the evidence of coverage booklet), must be preauthorized by Delta Dental to be covered by your DeltaCare USA program. DeltaCare's Customer Service Department can be reached at 1 (800) 422-4234.

X _____ Date
Signature Required for DeltaCare, Delta Dental's (HMO) Plan

SECTION 6 - BLUE VIEW VISION PLAN.

Participants must meet the Laborers Health and Welfare Plan's eligibility requirements for vision coverage to receive vision benefits. Please refer to the Benefit Chart in the Summary of Benefits booklet or the Summary Plan Description (SPD).

Participant in the Kaiser Permanente Plan may receive an eye exam at a Kaiser Permanente Facility to provide a prescription for eye wear or contact lenses. Eligible participants in the HMO, EPO and PPO plans should refer to the Blue View Vision benefit chart for eye wear or contact lenses in the Summary of Benefits booklet.

Reimbursement. For reimbursement of your vision claim, complete the Blue View Vision Reimbursement form available in the back of the Summary of Benefits booklet or online at <https://socalaborers.org/Members/HealthWelfareForms>. Reimbursement claims must be sent to Blue View Vision. (See address located at the bottom of the Blue View Vision Claim Form.)

