

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

Laborers Organizing Active Member - (PPO Med/Rx Only)

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.

4 Medical Plan Coverage 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.

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.

Prescription Drug Coverage

- Your prescription coverage is provided by Optum Rx. 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.

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.

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 _____

_____ PPO Plan - 276444 _____

Laborers Organizing Active Member - (PPO Med/Rx Only) Enrollment/Change Form

SECTION 1 - TO BE COMPLETED BY EMPLOYEE

Your preferred language is English Spanish

Employer Name:	Job Title:	Date of Hire:
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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? <input type="checkbox"/> No <input type="checkbox"/> Yes Part A <input type="checkbox"/> Effective Date: _____; Part B <input type="checkbox"/> Effective Date: _____	Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <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	
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		Effective Date of Dialysis: _____
	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)			Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Health Insurance Claim Number (HICN) or Medicare Number: _____			Effective Date of Transplant: _____		
	Reason for Disability if Under Age 65 _____					
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	
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		Effective Date of Dialysis: _____
	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)			Kidney Transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Health Insurance Claim Number (HICN) or Medicare Number: _____			Effective Date of Transplant: _____		
	Reason for Disability if Under Age 65 _____					
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	

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	
	Employer Name	Employer's Address (City, State, Zip Code)	Policy Effective Date	

SECTION 3 - DESIGNATION OF BENEFICIARY(IES): The Union Labor Life Insurance Company (Ullico).

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 Option : Laborers' PPO 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 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

