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

Active Member (PPO Med/Rx & Delta Dental)
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

- 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

- 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 not be enrolled for dental coverage.
- 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. 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 _____

_____ PPO Plan – 276444 ___ ___ ___ ___
_____ Delta Dental – 05419___ ___ ___ ___

Active Member (PPO Med/Rx & Delta Dental)

Enrollment/Change Form

SECTION 1 – TO BE COMPLETED BY EMPLOYEE Your preferred language is ☐ English ☐ Spanish

Employer Name:	Job Title:	Date of Hire:

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 ☐ Male ☐ 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: _____

(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 _____

Dialysis? ☐ Yes ☐ No
Effective Date of Dialysis:
_____

Kidney Transplant? ☐ Yes ☐ No
Effective Date of Transplant:
_____

✓	**Reason for Election** – Check all that apply and provide effective date	✓	**Add/Change** – Check all that apply and **provide effective date***
	Enrollment Reason: **Provide the date:** _____ **and check reason below:**	☐	Add Spouse/Dependent Child
☐	New Hire	☐	Name Change
☐	Loss of Coverage	☐	12-Month Plan Change
☐	Other Coverage (Explain): _____	☐	Address Change
		☐	Marital Status Change
		☐	Other: _____
		☐	**Effective Date:** _____ ***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.***

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 ☐ Male ☐ Female	Marriage Date (mm/dd/yyyy)

Are you receiving Medicare? ☐ No ☐ Yes

Part A ☐ Effective Date: _____; Part B ☐ Effective Date: _____

(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 _____

Dialysis? ☐ Yes ☐ No

Effective Date of Dialysis: _____

Kidney Transplant? ☐ Yes ☐ No

Effective Date of Transplant: _____

Are you covered or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage: ☐ Medical ☐ Dental ☐ 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? ☐ Yes ☐ No (If yes, provide address below.)

Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Physically or Mentally Disabled? ☐ Yes ☐ No

Are you receiving Medicare? ☐ No ☐ Yes

Part A ☐ Effective Date: _____; Part B ☐ Effective Date: _____

(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 _____

Dialysis? ☐ Yes ☐ No

Effective Date of Dialysis: _____

Kidney Transplant? ☐ Yes ☐ No

Effective Date of Transplant: _____

Are you covered or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage: ☐ Medical ☐ Dental ☐ 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? ☐ Yes ☐ No (If yes, provide address below.)

Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Physically or Mentally Disabled? ☐ Yes ☐ No

Are you receiving Medicare? ☐ No ☐ Yes

Part A ☐ Effective Date: _____; Part B ☐ Effective Date: _____

(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 _____

Dialysis? ☐ Yes ☐ No

Effective Date of Dialysis: _____

Kidney Transplant? ☐ Yes ☐ No

Effective Date of Transplant: _____

Are you covered or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)

Type of Coverage: ☐ Medical ☐ Dental ☐ 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? ☐ Yes ☐ No (If yes, provide address below.)			
	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Physically or Mentally Disabled? ☐ Yes ☐ No	
	Are you receiving Medicare? ☐ No ☐ Yes Part A ☐ Effective Date: _____; Part B ☐ Effective Date: _____ **(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 _____		Dialysis? ☐ Yes ☐ No Effective Date of Dialysis: _____ Kidney Transplant? ☐ Yes ☐ No Effective Date of Transplant: _____	
	Are you covered or enrolled in another group health plan? ☐ Yes ☐ No (If yes, provide the information below.)			
	Type of Coverage: ☐ Medical ☐ Dental ☐ 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 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 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 _____ _____

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 [✖].

Dental Plan Option: DeltaCare, Delta Dental's (HMO) 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.)*

	1st Choice Dental Office	Address of Dental Office	2nd 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 _____ _____

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

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).*

Eligible participants in the PPO plan 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.)