# SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND

## PLAN ENROLLMENT / CHANGE FORM

***Please print and thank you for providing this information***

**A**

**CHECK ACTION:** **EFFECTIVE DATE**

- ☐ **OPEN/NEW ENROLLMENT** ___ ___/___ ___/___ ___
- ☐ **REINSTATEMENT** ___ ___/___ ___/___ ___
- ☐ CHANGE OF ADDRESS
- ☐ NAME CHANGE
- ☐ ADD DEPENDENT/SPOUSE*
- ☐ DELETE DEPENDENT/SPOUSE*

* Indicate reason for change in dependent/spouse enrollment in Section B.
List dependent(s) to be added/deleted in Section F.

**B**

- ☐ **MARRIAGE (submit copy of marriage certificate)**
- ☐ **DIVORCE (submit copy of final decree)**
- ☐ **BIRTH (submit copy of birth certificate/s)**
- ☐ **ADOPTION (submit copy of adoption records)**

***Note: Be sure to submit copy of requested documentation***

**FOR OFFICE USE ONLY**

| **KAISER** | **United Concordia** |
|---|---|
| 109762-04 | 921683 |

**C**

| **SOCIAL SECURITY #** | **LAST NAME** | FIRST NAME | M.I. | BIRTHDATE | SEX ☐ M ☐ F |
|---|---|---|---|---|---|
| | | | | | |

| **HOME ADDRESS** | CITY | STATE | ZIP CODE | MARITAL STATUS | HOME PHONE |
|---|---|---|---|---|---|
| | | | | ☐ single ☐ divorced ☐ married ☐ widow | ( ) |

| **DATE HIRED** | **EMPLOYER NAME** | UNION LOCAL | NAME CHANGE: FROM: TO: |
|---|---|---|---|
| | | | |

**I HAVE REVIEWED THE PLAN OPTIONS AVAILABLE AND ELECT COVERAGE UNDER THE PLAN INITIALED BELOW. I UNDERSTAND BENEFITS WILL ONLY BE AVAILABLE FROM THE PLAN IN WHICH I HAVE ENROLLED.**

**D**

☐ Kaiser Permanente

☐ Indemnity Plan

**PLAN PARTICIPANTS:**

Please designate the plan of your choice by placing your initials in the box next to the plan you wish to enroll in.

**E**

☐ United Concordia

☐ Scheduled Dental Plan

If you are enrolling in United Concordia, indicate below the number of the dental office you will use. Each family member may enroll in a different dental office.

**F**

**INITIAL ONE**

☐ I elect to enroll the dependents listed below. I have read the definition of eligible dependents listed on the back of this form and certify that they are eligible to be enrolled at this time. I understand I must provide proof of eligible dependent status by submitting certified copies of marriage and/or birth certificates for each dependent being enrolled. I further understand that dependent coverage is subject to the Fund receiving the contribution required to provide dependent coverage.

☐ I have dependents, but I elect not to cover my dependents under the Plan. I understand that I cannot enroll dependents later, except by written request during the Open Enrollment period in November of each year. (NOTE: This does not apply to newly aquired dependents.)

☐ I elect to delete the dependents listed below. I understand that I may not re-enroll these dependents until the next open enrollment period. Once deleted, these dependents will not be eligible for any of the benefits provided under the Plan.

SPOUSE / FAMILY INFORMATION Please list eligible members to be enrolled.
See back of this form for definition of eligible family members.

| **Last Name** / **First Name** / **M.I.** | **DATE OF BIRTH** Month Day Year | **SEX** | **SOCIAL SECURITY NO.** (Required for Enrollment) | **United Concordia Dental Office** |
|---|---|---|---|---|
| Self | | ☐ **M** ☐ **F** | | |
| Spouse/Dcomestic Partner | | ☐ **M** ☐ **F** | | |
| Dependent* Relationship | | ☐ **M** ☐ **F** | | |
| Dependent* Relationship | | ☐ **M** ☐ **F** | | |
| Dependent* Relationship | | ☐ **M** ☐ **F** | | |

***DEPENDENTS - If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled, attach proof of disability for eligibility review.**

**G**

DEPENDENT'S ADDRESS ( if different from subscriber): ☐ Check here if all dependents are at the address below.

| Name(s) | Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**H**

**OTHER HEALTH CARE COVERAGE:**

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No **MEDICARE** **Part A** ☐ **Part B** ☐

If yes, please provide the following:

| **NAME OF PERSON COVERED** | **SOCIAL SECURITY NO.** | **EMPLOYER** | **INSURANCE COMPANY NAME AND ADDRESS** |
|---|---|---|---|
| | | | |

Have you or your dependent(s) ever been covered by Kaiser? ☐ **Yes** ☐ **No**

If yes, please give the following information from your Kaiser Card.

| **GROUP NUMBER** | **FAMILY ACCOUNT #** |
|---|---|
| | |

All questions with respect to Plan participation, eligibility for benefits, the nature and amount of benefits or with respect to any matter of Plan administration must be referred to the Fund Office or to the Board of Trustees. No participating employer, employer association or labor organization or any individual employed thereby has any authority to answer any questions regarding the Trust Fund in this regard. I UNDERSTAND THIS ELECTION WILL REMAIN IN EFFECT UNTIL I MAKE ANOTHER ELECTION DURING AN OPEN ENROLLMENT PERIOD. I further understand it is my responsibility to read the Plan booklets and other Plan information sent to me so that I know how to use the Plan, and what benefits are payable thereunder and which appeal rules apply to any denied claims. I also hereby authorize the release of information, documents, etc. by any third party, including the Southern California Lumber Industry Welfare Fund, if the release of information is determined to be necessary to the review or payment of any claim, or to make an eligibility determination. If enrolled in an HMO plan, I understand that any controversy between any HMO plan member and such HMO (including its agents, staff physician, employees, and providers) may be subject to binding arbitration. For additional information about each plan's arbitration provision, please refer to the Evidence of Coverage which is available from your Group. I certify under penalty of perjury under the laws of the state of California that I understand the foregoing and information I have provided is true and correct.

EMPLOYEE SIGNATURE_____ DATE SIGNED_____

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