EMPLOYERS MANAGED HEALTH CARE TRUST

Enrollment Application
Actives & Non Medicare Retirees

INSTRUCTIONS:
Complete EACH section front and back.
Sign and Date. Use Ink
For questions, call (800) 924-1226

MAIL TO:
Employers Managed Health Care Trust
P.O. Box 757
Pleasanton, CA 94566
Fax: (925) 426-3565
www.emtrust.org

INSTRUCTIONS: (Please read carefully before completing the Enrollment Form)

It is extremely important that all plan participants complete and sign an enrollment application to ensure benefit coverage. Be sure to complete all of the information requested. If enrolling in a UnitedHealthcare HMO Plan, please make sure to complete the PCP Selection on page 2 of the enrollment application. If your group offers a life insurance benefit, please remember to designate a beneficiary. Additionally, when listing eligible dependents, state law requires that all social security numbers be provided. Please note that if you do not select a medical or dental provider within your first three (3) months of eligibility, Kaiser Permanente and Liberty Dental Plan (if applicable) will be your only options upon enrollment and you will be required to remain with Kaiser Permanente and Liberty Dental Plan (if applicable) for a minimum of 12 months. Upon completion of the 12 months, the Trust Fund utilizes a Self-Directed enrollment which allows you the option to change your medical and or dental providers (if applicable) at any time during the year in accordance with the following guideline:

- Plan participants can change medical and dental providers one time within a twelve (12) month period.

TO ADD OR CHANGE YOUR DEPENDENTS, THE FOLLOWING DOCUMENTATION IS REQUIRED:

- Copies of certified Marriage Certificate if adding a Spouse with a different last name.
- Copies of the certified Birth Certificates if adding dependent children with a different last name.
- Court appointed & adopted children: Proof of Legal guardianship or Decree of Adoption.

ELIGIBLE DEPENDENTS ARE:

1. Your lawful spouse.
2. Your children (including stepchildren, legally adopted children and children for whom you or your spouse is the court appointed guardian) less than 26 years of age.
3. Your children age 26 or older, residing with and dependent upon you for support, which are incapable of self-support because of mental or physical disability that existed prior to reaching age 26.
4. Your domestic partner meeting the requirement referenced in the Summary Plan Description.

Upon completion, please return the Enrollment Application to the Plan Administrative Office. You must also report any future changes (e.g., address or dependents) to the Plan Administrative Office. Additional Enrollment Applications can be obtained from the Plan Administrative Office, your Local Union, or on the Trust Fund website at www.emttrust.org.

EMPLOYERS MANAGED HEALTH CARE TRUST

PLEASE CHECK ALL THAT APPLY:

☐ New Hire ☐ Re-Hire
☐ Open Enrollment
☐ New Employer

TYPE OF CHANGE – CURRENT TRUST PARTICIPANT:

☐ Name
☐ Address
☐ Add/Delete Dependent(s)
☐ Medical
☐ Dental
☐ Life Beneficiary

Marital Status
☐ Married
☐ Divorced

CHOICE OF MEDICAL PLANS (Actives/Non-Medicare Retirees only)**:**

☐ Kaiser Permanente HMO (Signature Required on Pg. 2)
☐ UnitedHealthcare HMO (Signature Required on Pg. 2)
☐ UnitedHealthcare PPO (Signature Required on Pg. 2)

CHOICE OF DENTAL PLANS (if applicable):

☐ Liberty Dental Plan DHMO
- **Office ID #:**_____

☐ UnitedHealthcare DHMO
☐ Delta Dental PPO

LIFE INSURANCE BENEFICIARY:

Name: _____ Relationship: _____ Phone Number: _____
Home Address:_____ Email Address: _____

SECTION I – EMPLOYEE INFORMATION

Last Name	**First Name**	**M.I.**	**Social Security Number**
Mailing Address		**Gender** ☐ M ☐ F	**Date of Birth (mm/dd/yyyy)**
City	**State**	**Zip**	**Marital Status** ☐ Single ☐ Married
Home Telephone Number	**Cell Phone Number**	**Email Address**	
Employer		**Date of Hire**	**Local Union Number**

SECTION II – DEPENDENT INFORMATION

(Additional dependents may be listed on a separate sheet. Please ensure all required dependent information/documents are provided.)

Relation	Add/Delete	Last Name	First Name	Gender	Date of Birth	Social Security #/TIN
Spouse	☐ Add ☐ Delete			☐ M ☐ F		
Dependent	☐ Add ☐ Delete			☐ M ☐ F		
Dependent	☐ Add ☐ Delete			☐ M ☐ F		
Dependent	☐ Add ☐ Delete			☐ M ☐ F		
Dependent	☐ Add ☐ Delete			☐ M ☐ F		

SECTION III – OTHER INSURANCE INFORMATION

(Please complete this section below if you or a dependent have other insurance coverage.)

Name of Insured Person:	**Insurance Company Name:**	
Effective Date of Coverage:	**Policy #:**	**Telephone #:**
Medicare Eligible: ☐ **Yes** ☐ **No** **Name:**	**Medicare ID #:**	

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that failure to disclose true and accurate information may result in the immediate termination of the benefits. I hereby authorize the release of any necessary health information on those family members who become covered for benefits to the Plan Manager by their attending physicians.

SIGNATURE OF PARTICIPANT: _____ **DATE:** _____

THIS FORM MUST BE SIGNED AND DATED TO PROCESS YOUR ENROLLMENT

OVER →

ADMINISTRATIVE USE ONLY			
☐Composite Plan	Tiered Plan: ☐Single ☐Two Party ☐Family		
Effective Date:	**Employer Code:**	**Plan Code:**	**Date:**
Medical Group #:	**Sub-Group #:**	**Dental Group #:**	**Sub-Group #:**

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*.

SIGNATURE OF PARTICIPANT: _____ **DATE:** _____
(Required if electing Kaiser Permanente)

UnitedHealthcare Arbitration Agreement. I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthcare of California, UnitedHealthcare or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitrations. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for Judicial Review of Arbitration proceeding. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a Court of Law before a jury, and instead are accepting the use of binding arbitration.

Please note that you are required to complete the PCP Selection at the bottom of this page, if enrolling in a UnitedHealthcare HMO Plan.

SIGNATURE OF PARTICIPANT: _____ **DATE:** _____
(Required if electing UnitedHealthcare)

NOTE: The following section only needs to be completed if you are enrolling in a UnitedHealthcare HMO Plan.

UnitedHealthcare HMO – PCP Selection

1	**Self**	**Last Name**	**First Name**	**Social Security #/TIN**	**Date of Birth**
	☐ Male ☐ Female	**Primary Care Physician (PCP)/Medical Group Name**		**Provider #**	**Existing Patient?** ☐ Yes ☐ No
2	**Spouse**	**Last Name**	**First Name**	**Social Security #/TIN**	**Date of Birth**
	☐ Male ☐ Female	**Primary Care Physician (PCP)/Medical Group Name**		**Provider #**	**Existing Patient?** ☐ Yes ☐ No
3	**Dependent**	**Last Name**	**First Name**	**Social Security #/TIN**	**Date of Birth**
	☐ Male ☐ Female	**Primary Care Physician (PCP)/Medical Group Name**		**Provider #**	**Existing Patient?** ☐ Yes ☐ No
4	**Dependent**	**Last Name**	**First Name**	**Social Security #/TIN**	**Date of Birth**
	☐ Male ☐ Female	**Primary Care Physician (PCP)/Medical Group Name**		**Provider #**	**Existing Patient?** ☐ Yes ☐ No
5	**Dependent**	**Last Name**	**First Name**	**Social Security #/TIN**	**Date of Birth**
	☐ Male ☐ Female	**Primary Care Physician (PCP)/Medical Group Name**		**Provider #**	**Existing Patient?** ☐ Yes ☐ No