

INSTRUCTIONS Please also read the important information on the back of the form.

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health & Welfare coverage. Be sure to complete **all** of the information requested on the Enrollment Form. If you move into Plan A coverage, you can request to enroll in an HMO from when your Plan A coverage becomes effective through the end of the next Open Enrollment Period. Be sure to complete the box marked **COVERAGE SELECTION** if you are requesting a Plan change.

Please read your Summary Plan Description for descriptions of the various plans. Remember, once you make the election you will not be permitted to change your Plan until the next annual Open Enrollment period each year (changes effective January 1).

TO ADD OR CHANGE COVERAGE FOR YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION IS REQUIRED

- Copies of certified Marriage Certificate or Divorce papers must be submitted.
- Copy of a Certificate of Registration of Domestic Partnership must be submitted to add your Domestic Partners and or dependents.
- Copies of certified Birth Certificates must be submitted for dependent children.
- Stepchildren, including any children of your Domestic Partner must live with and be primarily dependent on you for support. Verification of support required on request.
- Foster & Adopted children: Legal Guardianship or Court adoption papers are required. The child/children must live with you.
- Student certification for full-time student required for dependent children ages 19-23.

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES.

Please check one of the boxes below to indicate if this is a new enrollment or a change request.

NEW HIRE (Complete next 2 lines)
 Employer: _____
 Date of Hire: _____

TRANSFER FROM RECIPROCAL FUND
 If Reciprocal Fund is Southern California Wholesale Butchers, attach **REQUEST FOR TRANSFER OF CREDITS FORM**

Prior Job Location/Local: _____
 Date of Transfer: ; _____

NOTIFICATION OF CHANGE

- CHANGE OF NAME
- CHANGE OF MARITAL STATUS
- CHANGE OF DEPENDENTS
- CHANGE OF BENEFICIARY
- CHANGE OF PLAN
- RETURN FROM MILITARY SERVICE (Attach copy of Form DD-214)

Section 1 COVERAGE SELECTION

Medical Plan
 I select: Indemnity Open Plan (PPO) Kaiser* Health Net
 *If you select Kaiser and were previously covered by Kaiser, please provide your Kaiser Medical Record # in Section 2 and for other family members in Section 3.
Under Plan B/Ultra Plan or Plan C/Standard, HMO coverage is not an option.

Dental Plan
 I Select:
 Premier Access
 Liberty Dental (Plan A/Premier and Plan B/Ultra Only)

Section 2 PARTICIPANT / EMPLOYEE INFORMATION

Last Name		First Name		Initial	Gender	Social Security #		Union Local
Mailing Address (Street or P. O. Box)				<input type="checkbox"/> New	City		State	Zip Code
Telephone Number	Current Marital Status			Date of Marriage/Divorce/ Dom Partner Cert. (MM/DD/YY)	Date of Birth (MM/DD/YY)	Kaiser Medical Record#		
Email	<input type="checkbox"/> Never Married	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed				
<input type="checkbox"/> Domestic Partner								

Section 3 DEPENDENT(S) INFORMATION Dependent coverage for children only under Plan C/Standard. Not applicable to Courtesy Clerks

Last Name	First Name	Relation	Gender	Date of Birth (MM/DD/YY)	Dependent Social Security# (Required)	Kaiser Medical Record#
Spouse/Domestic Partner						
Dependent 1						
Dependent 2						
Dependent 3						

Section 4 BENEFICIARY OF DEATH BENEFIT

Beneficiary's Last Name		First Name		Initial	Relationship	Social Security # or Tax ID #		%
Street Address				City		State	Zip Code	
Beneficiary's Last Name		First Name		Initial	Relationship	Social Security # or Tax ID #		%
Street Address				City		State	Zip Code	
Beneficiary's Last Name		First Name		Initial	Relationship	Social Security # or Tax ID #		%
Street Address				City		State	Zip Code	

SIGNATURE REQUIRED ON BACK

Section 5 SPOUSE/DOMESTIC PARTNER EMPLOYMENT AND OTHER INSURANCE MUST BE COMPLETED EVERY YEAR

Please note that under Plan rules your Spouse's/Domestic Partner's failure to obtain health insurance coverage provided by his/her Employer may result in a reduction of benefits provided by this Plan. If your Spouse/Domestic Partner is retired, and receives retiree coverage from his/her employer, that coverage should be listed in Section 6. See enclosures for additional information about this requirement.

Is your Spouse/Domestic Partner currently employed? Yes No If 'No', skip the rest of Section 5, and go to Section 6. If 'Yes', please complete all of this section.

Name of Spouse's/Domestic Partner's Employer: _____ Employer's Telephone: _____

Street Address _____ City _____ State _____ Zip Code _____

Does your Spouse's/Domestic Partner's Employer provide any health insurance coverage or funds which can be used for insurance coverage? Yes No If 'No', skip the rest of Section 5.

If your Spouse/Domestic Partner is enrolled in a Plan, mark the 'Yes' box and provide information about the Insurance Carrier.
If your Spouse/Domestic Partner is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Spouse/DP Enrolled in Medical/Rx Plan? Yes Effective date: _____ Carrier: _____
Plan covers: Employee only Employee and Family **Check here if HMO** **or PPO**
 No **Check one of the following:** Not offered by Employer
 Offered by Employer Employee monthly cost: \$ _____

Spouse/DP Enrolled in Dental Plan? Yes Effective date: _____ Carrier: _____
Plan covers: Employee only Employee and Family
 No **Check one of the following:** Not offered by Employer
 Offered by Employer Employee monthly cost: \$ _____

Spouse/DP Enrolled in Vision Plan? Yes Effective date: _____ Carrier: _____
Plan covers: Employee only Employee and Family
 No **Check one of the following:** Not offered by Employer
 Offered by Employer Employee monthly cost: \$ _____

Next Open Enrollment Period for Spouse's/Domestic Partner's Employer Month: _____ Year: _____

Section 6 OTHER INSURANCE COVERAGE FOR YOU OR YOUR DEPENDENT(S)

List any other insurance coverage you may have for you and your enrolled Spouse/Domestic Partner and Dependent(s).

Are you covered by Medicare? Yes No Is your Spouse/Domestic Partner covered by Medicare? Yes No

Are you or any of your dependent(s) covered by any other Group Insurance? Yes No Covered Person's Name(s): _____

Other Insurance Carrier: _____ HMO: Yes No Effective Date: _____

Section 7 PARTICIPANT & SPOUSE/DOMESTIC PARTNER CERTIFICATION (PLEASE READ & SIGN BELOW)

FRAUD NOTICE: I UNDERSTAND THAT I MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTIES FOR COMMITTING A FRAUDULENT INSURANCE ACT IF I KNOWINGLY PROVIDE ANY MATERIALLY FALSE INFORMATION TO, OR CONCEAL ANY MATERIAL FACTS FROM, THE TRUST FUND WITH THE INTENT TO DEFRAUD OR MISLEAD THE TRUST FUND.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION: I AUTHORIZE MY PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN LISTED ABOVE, OR THE TRUST FUND ANY AND ALL INFORMATION OR RECORDS PERTAINING TO MEDICAL HISTORY, INCLUDING SERVICES RENDERED, OR TREATMENT GIVEN TO ANYONE ENROLLED NOW OR ADDED LATER FOR THE PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM INTERNAL ADMINISTRATIVE FUNCTIONS. I UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY CONFIDENTIAL INFORMATION TO OTHERS. ANY SUCH DISCLOSURE SHALL BE MADE IN COMPLIANCE WITH ALL APPLICABLE LAWS. THE TRUST FUND, ITS AGENTS OR EMPLOYEES, SHALL USE ALL REASONABLE SAFEGUARDS TO ENSURE THAT ANY USE OR DISCLOSURE OF MY CONFIDENTIAL INFORMATION IS SOLELY FOR THE PURPOSE OF ADMINISTERING BENEFITS UNDER THE PLAN.

ARBITRATION: I AGREE THAT ANY DISPUTE OR CONTROVERSY WHICH MAY ARISE BETWEEN MYSELF OR ANY FAMILY MEMBER AND A PREPAID PLAN OR HEALTH MAINTENANCE ORGANIZATION (HMO), OR ANY OF ITS PROVIDERS, SHALL BE SETTLED BY THE PREPAID PLANS OR HMOS FINAL AND BINDING ARBITRATION RULES, IF ANY.

SPOUSE'S/DOMESTIC PARTNER CONSENT TO DISCLOSURE OF SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION: BY MY SIGNATURE BELOW, I AUTHORIZE THE TRUST FUND TO OBTAIN MY SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION FROM MY EMPLOYER FOR THE PURPOSE OF DETERMINING THE LEVEL OF MY BENEFITS AS A DEPENDENT UNDER THE PLAN.

SIGNATURE REQUIRED: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM, WHICH I HAVE FULLY READ AND UNDERSTAND.

Participant's Signature: _____ Date: _____
Spouse's Signature: _____
or
Domestic Partner's Signature: _____

This form is not acceptable if it is not signed!