PENSIONED OPERATING ENGINEERS HEALTH AND WELFARE FUND

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HAWAII MEDICARE RETIREE ENROLLMENT FORM

☐ NEW MEMBER OR CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ PLAN ☐ ADDRESS ☐ DEPENDENTS

COMPLETE ALL INFORMATION – PLEASE PRINT IN INK

PARTICIPANT DATA

LAST NAME	FIRST NAME	M.I.	FULL SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)			GENDER (M/F)	DATE OF BIRTH
CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
EMAIL ADDRESS	FORMER EMPLOYER		DATE OF TERMINATION	
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			DATE OF MOST RECENT MARRIAGE/DIVORCE	

CHOICE OF PLANS
MEDICAL SELECTION – CHOOSE ONE:

☐ **COMPREHENSIVE** (1)
☐ **KAISER SENIOR ADVANTAGE** (2)(3)
☐ **AKAMAI ADVANTGE GROUP** (2)(3)
(EGWP MAPD LPPO 595)(2)(3)20370-1-8

NOTES:
(1) THIS FORM SERVES AS YOUR ENROLLMENT FORM FOR THIS PLAN.
(2) YOU MUST COMPLETE A SEPARATE FORM IF YOU SELECT THESE PROVIDERS.
(3) YOU MUST BE ENROLLED IN BOTH MEDICARE PARTS A & B – **SEND A COPY OF YOUR MEDICARE CARD.**

ARE YOU ELIGIBLE FOR MEDICARE PARTS A & B?

☐ YES EFFECTIVE DATE_____
☐ NO

IF YOU SELECT KAISER AS YOUR MEDICAL PLAN AND WERE PREVIOUSLY COVERED BY KAISER, PROVIDE YOUR KAISER MEDICAL RECORD NUMBER (IF ANY)_____

FAMILY DATA

PROVIDE THE SOCIAL SECURITY NUMBER OF EACH DEPENDENT YOU ENROLL.
FEDERAL REGULATIONS REQUIRE HEALTH PLANS TO REPORT THE NAMES AND SOCIAL SECURITY NUMBERS OF EVERY COVERED INDIVIDUAL TO THE IRS.

FULL NAME	RELATION*	GENDER (M/F)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	OTHER INSURANCE? (see below)	ADDRESS SAME AS MEMBER? (If no, provide below)
SPOUSE					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐
DEPENDENT CHILD					YES ☐ No ☐	YES ☐ No ☐

*Relation – Son Daughter, Stepson, Stepdaughter, Adopted child, etc.

LIST ANY ENROLLEE WHO IS ENTITLED TO BENEFITS FROM ANOTHER GROUP HEALTH CARE, INSURANCE, OR PRE-PAID MEDICAL PLAN:

Dependent:		Insurance Company		Policy #	
Dependent:		Insurance Company		Policy #	
Dependent:		Insurance Company		Policy #	
Dependent:		Insurance Company		Policy #	

If a dependent child is listed above, I authorize a deduction of $179.00 per child for medical, prescription drug (if applicable), vision care (if applicable) and any additional deduction required for the dental coverage. All provisions of the Pension Deduction Authorization currently on file with the fund for me apply to this authorization. If additional space is required, use the back of this form.

Any change in plans will be effective the first day of the second calendar month following the date the Trust Fund Office receives your enrollment form (per the Summary Plan Description).

When you enroll in a plan option you must remain in the plan for at least 12 months. An exception will be made only if you elected an HMO and you move out of the HMO service area or it ceases to be available where you live (or the Board approves a change).

*****THIS FORM MUST BE SIGNED TO PROCESS YOUR ENROLLMENT SELECTION*****

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Important Notice: I apply for Health Plan membership for the persons listed and agree that we shall abide by the provisions of the Health Maintenance Organization (HMO) service agreement or preferred provider plan regulations, whichever applies. I understand that the service agreement provides that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me, believed that some conduct in, or arising from my relationship with the HMO, HMO hospitals, or the HMO medical group, as a member or as a patient, has caused any harm, must be submitted to binding arbitration instead of court trial.

I understand that the Pensioned Operating Engineers Health and Welfare Trust Fund has no enforceable right in, or to my Pension Plan benefit payment or portion thereof, except the payments actually received by the Health and Welfare Fund pursuant to this authorization. I also understand that I may revoke this authorization at any time if I notify the Pension Plan, in writing, of my with to terminate the deduction, and that in the event of such termination the Health and Welfare coverage for myself and/or my dependent child(ren) will also terminate and I will not be able to reenroll at a later date.

Kaiser Permanente Health Plan Arbitration Agreement: I understand that, except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and if your Group must comply with ERISA regarding certain benefit-related disputes, any dispute between myself, my heirs, or other associated parties on the one hand and Health Plan, its Health Care Providers, or other associated Parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for Medical or Hospital malpractice, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the arbitration provision is contained in the Evidence of Coverage.

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MEMBER SIGNATURE_____ **DATE**_____