CALIFORNIA SERVICE EMPLOYEES HEALTH & WELFARE TRUST FUND

Los Angeles Office: 828 West Washington Blvd • Los Angeles CA 90015 • Phone 213.747.7551 • 877.492.2778
Claims Office: 2323 Eastlake Ave East • Seattle WA 98102 • Phone 844.492.9158

PLEASE CHECK ALL THAT APPLY

- ◯ NEW HIRE
- ◯ CHANGE OF: ☐ NAME ☐ MARITAL STATUS ☐ ADDRESS ☐ ADD/DELETE DEPENDENTS ☐ PLAN ☐ SOCIAL SECURITY NUMBER

TRUST FUND OFFICE USE ONLY:

KAISER GROUP NO.	ENROLLMENT UNIT
NEW ENROLLMENT EFFECTIVE DATE (MM/DD/YY)	
ENROLLMENT CHANGE EVENT DATE (MM/DD/YY)	

SECTION I - EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	M. I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)		APT #	SEX (M/F)	DATE OF BIRTH (MM/DD/YYYY)
CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
MARITAL STATUS ◯ SINGLE ◯ MARRIED ◯ DIVORCE	EMPLOYER	LOCAL #		DATE OF HIRE (MM/DD/YYYY)

PLEASE CHECK YOUR CONTRACT TO CONFIRM YOUR OPTIONS FOR DENTAL BENEFITS BEFORE MAKING YOUR SELECTION

CHOICE OF DENTAL PLANS
- ◯ DELTACARE® USA
- ◯ SELF-FUNDED DENTAL PLAN

MEDICAL PLAN:
KAISER PERMANENTE TRADITIONAL PLAN

SECTION II - EMPLOYEE AND DEPENDENT PERSONAL DATA

RELATION*	LAST NAME	FIRST NAME	SEX	DATE OF BIRTH	SOCIAL SECURITY #.	Receiving Medicare Part A or B	Kidney Transplant or Dialysis
Self						☐ YES ☐ NO	☐ YES ☐ NO
☐ Spouse* ☐ Domestic Partner**						☐ YES ☐ NO	☐ YES ☐ NO
Dependent*						☐ YES ☐ NO	☐ YES ☐ NO
Dependent*						☐ YES ☐ NO	☐ YES ☐ NO
Dependent*						☐ YES ☐ NO	☐ YES ☐ NO

*** Attach copies of Marriage Certificate for dependent spouse. Attach copies of Birth Certificates for dependent children up to age 26**
**** Domestic Partner – the member must apply and qualify separately for Domestic Partner eligibility through the Trust Fund Office.**

DO YOU OR YOUR DEPENDENTS HAVE OTHER INSURANCE? YES NO

IF YES, PLEASE GIVE THE INSURANCE NAME, ADDRESS & POLICY #: _____

PLEASE COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF MEDICARE CARD IF YOU OR A DEPENDENT ARE ENROLLED IN MEDICARE

Please list the individual receiving Medicare	Receiving Part A?	YES	NO	If yes, Effective date: ____/____/____
Name:_____	Receiving Part B?	YES	NO	If yes, Effective date: ____/____/____
Please list the individual receiving Medicare	Receiving Part A?	YES	NO	If yes, Effective date: ____/____/____
Name:_____	Receiving Part B?	YES	NO	If yes, Effective date: ____/____/____

YOU MUST COMPLETE THE SECTION BELOW IF YOU CHECKED "YES" TO TRANSPLANT OR RECEIVING KIDNEY DIALYSIS

Please list the individual receiving Kidney Transplant/Dialysis	Receiving Kidney Transplant?	YES	NO	If yes, Effective date: ____/____/____
Name:_____	Receiving Dialysis?	YES	NO	If yes, Effective date: ____/____/____
Please list the individual receiving Kidney Transplant/Dialysis	Receiving Kidney Transplant?	YES	NO	If yes, Effective date: ____/____/____
Name:_____	Receiving Dialysis?	YES	NO	If yes, Effective date: ____/____/____

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 can't 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 and, 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 service were unnecessary or unauthorized or were improperly, negligently or incompletely 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 Required for the Kaiser Permanente Plan**

_____ **Date**

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