EMPLOYEE ENROLLMENT/CHANGE FORM

PLEASE PRINT LEGIBLY

TO BE COMPLETED BY EMPLOYER

Effective Date: _____

Reason for Enrollment	Class	Change	Terminate
☐ New Hire	☒ Apprentice	☐ Add Spouse	☐ Remove Spouse
☐ Open Enrollment		☐ Add Child(ren)	☐ Remove Child(ren)
☐ Rehire		☐ Address	
☐ QMCSO			

Qualifying Event: _____

Date Event Occurred: _____

Attach Required Supporting Documentation

A Qualifying Life Event is a term defined by the IRS to describe events that may allow participants to change their benefit elections outside of an Open Enrollment period. Examples include but are not limited to: Adoption, Birth, Marriage, and Involuntary Loss of Coverage.

TO BE COMPLETED BY EMPLOYEE

Employer Name			
Employee Last Name	Employee First Name		MI
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female	
Street Address	City	State CA	Zip Code
Email	Phone		

BENEFIT SELECTION

Please Note: Apprentices are Limited to <u>one</u> Dependent Selection to cover <u>all Products</u>

Medical Plan: United HealthCare Low HMO			**Group Number:** 908305-0005
☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
Dental Plan: Reliance Standard PPO – Ameritas Classic PPO Network			**Group Number:** 136-421223-3
☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
Vision Plan: EyeMed PPO			**Group Number:** 1022193-1001
☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child(ren)	☐ Employee + Family
Term Life and AD&D Plan: Reliance Standard $25,000			**Group Number:** GL154229

EMPLOYEE AND DEPENDENT INFORMATION

List yourself and family members to be covered – attach additional sheets if necessary

Self	Primary Care Physician (PCP) Name		PCP Provider Number	Existing Patient? ☐ Yes ☐ No
Spouse/Domestic Partner	☐ Male ☐ Female	Last Name	First Name	MI
Social Security Number		Date of Birth (mm/dd/yyyy)	Address, if different from employee's address	
Primary Care Physician (PCP) Name			PCP Provider Number	Existing Patient? ☐ Yes ☐ No
Child 1	☐ Male ☐ Female	Last Name	First Name	MI
Social Security Number		Date of Birth (mm/dd/yyyy)	Address, if different from employee's address	
Primary Care Physician (PCP) Name			PCP Provider Number	Existing Patient? ☐ Yes ☐ No
Child 2	☐ Male ☐ Female	Last Name	First Name	MI
Social Security Number		Date of Birth (mm/dd/yyyy)	Address, if different from employee's address	
Primary Care Physician (PCP) Name			PCP Provider Number	Existing Patient? ☐ Yes ☐ No
Child 3	☐ Male ☐ Female	Last Name	First Name	MI
Social Security Number		Date of Birth (mm/dd/yyyy)	Address, if different from employee's address	
Primary Care Physician (PCP) Name			PCP Provider Number	Existing Patient? ☐ Yes ☐ No

LIFE INSURANCE BENEFICIARY INFORMATION

Primary Beneficiary Designation (% Must Equal 100%)

Last Name	First Name	MI	Relationship	Percentage
Address		Social Security Number		
Last Name	First Name	MI	Relationship	Percentage
Address		Social Security Number		

Contingent Beneficiary Designation (% Must Equal 100%)

Last Name	First Name	MI	Relationship	Percentage
Address		Social Security Number		
Last Name	First Name	MI	Relationship	Percentage
Address		Social Security Number		

EMPLOYEE STATEMENTS AND AGREEMENTS (Read Carefully – Signature Required)

By signing below, I acknowledge that I have read, understand and agree to Binding Arbitration. A reproduction of this authorization shall be as valid as the original.

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 HEIRS OR ASSIGNS) AND THE INSURANCE CARRIER(S) OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIEATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. 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 PROCEDINGS. 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.

I understand the effective date of coverage will be determined by the terms and eligibility requirements of the Trust. I understand that changes to my Benefit Selections can only be made following a Qualifying Life Event. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct.

Signature	Date