Last Name	First Name	MI	Social Security Number

MEDICAL/DENTAL ENROLLMENT

MARITAL STATUS (Check One)

	Single		
	Married	Date of Marriage	/ /
	Separated	Date of Separation	/ /
	Divorced	Date of Dissolution	/ /
	Domestic Partnership	Date of Domestic Partnership Registration	/ /
	Widowed	Date of Death of Spouse	/ /

You must remove your ex-spouse or domestic partner (and any step-children) within 30 days of your divorce or the dissolution of your domestic partnership.

SOUTHWEST CARPENTERS HEALTH & WELFARE PLAN SELECTION

Coverage is subject to the Health Plan eligibility rules and the applicable labor agreement.
Your actual work history may invalidate your plan selection and require additional enrollment.

ACTIVE MEDICAL PLAN

Select your Medical and Dental Plan
Enrollment includes eligible dependents.

MEDICAL PLAN OPTIONS (CHECK ONE)

	Active Medical PPO Plan (Available in all States)
	Kaiser Permanente HMO Plan (Available in CA and CO only)

DENTAL PLAN OPTIONS (CHECK ONE)

	UnitedHealthCare Dental PPO Plan (Available in all States)
	UnitedHealthCare Dental DHMO **DC Plan** (CA/NV) or **INO Plan** (AZ, CO, UT, WA, WY)

BRONZE MEDICAL PLAN

Offered in Drywall Agreements in AZ, CO, NM, and UT or by CBA.
Making changes between the Active and Bronze Medical Plans may result in a change to your base pay rate.

Apprentices default to the Bronze Plan by agreement:
AZ & CA - 1st & 2nd period / NV - 1st thru 3rd period

(Millwrights excluded)

Medical coverage only, no dental or vision
Dependents may be added with a monthly self-payment

1 - dependent = $150 per month
2 or more dependents = $250 per month

	CHECK HERE to select the Bronze Medical PPO Plan

ENROLLING DEPENDENTS*

Spouse or Domestic Pt.	Add / Remove		Social Security Number		Date of Birth		
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #1	Add / Remove		Social Security Number		Date of Birth		
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #2	Add / Remove		Social Security Number		Date of Birth		
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #3	Add / Remove		Social Security Number		Date of Birth		
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #4	Add / Remove		Social Security Number		Date of Birth		
Last Name	First Name		MI	Sex	Male / Female		

*Attach a separate sheet to add additional dependents.

Last Name	First Name	MI	Social Security Number

To complete enrollment of your spouse/domestic partner and/or dependents, the following documents must be provided:

- Copy of Certified Marriage Certificate and your most recent tax return to enroll your spouse
- Copy of a Domestic Partnership Registration from a Government Agency and the Domestic Partner Enrollment Affidavit to enroll a Domestic Partner
- Copy of Certified Birth Certificate, Legal Guardianship, or Adoption Decree to enroll a dependent child

I hereby declare that all the statements made on the previous page are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance coverage may be issued. I agree on behalf of myself and the dependents listed that we are subject to the provisions of the applicable Summary Plan Description and all plan documents.

I understand that the Dental benefit plan I have selected provides reimbursement for certain Dental costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental expenses which I have incurred may not be covered by my Dental benefit plan. The Certificates provide Dental benefits only. Review your Certificates carefully.

FRAUD WARNING NOTICE: Providing false, incomplete or misleading information for any insurance policy shall not bar the right to recovery unless the statement was made with the actual intent to deceive, or it materially affects the acceptance of the risk or the hazard assumed by the insurers.

California law prohibits any HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signature	Date

Kaiser Foundation Health Plan, Inc., 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	Date

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*