



**CEMENT MASONS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**
4160 Dublin Blvd, Suite 400
Dublin, CA 94568
 Telephone: (707) 864-3300 or (888) 245-5005
 Email Address: nccmenrollment@hsba.com

FUND OFFICE USE ONLY (536)

EFF. DATE:

HCID: HA

ELIGIBILITY CODE/GROUP NO.:

ACTIVE PLAN APPLICATION FORM

PARTICIPANT INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER		NAME: FIRST		MIDDLE	LAST	
RESIDENCE ADDRESS (not Post Office Box)				CITY	STATE ZIP CODE	
TELEPHONE NO. ()	LOCAL UNION	DATE OF BIRTH			GENDER	MARITAL STATUS
		MONTH	DAY	YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

BENEFIT HEALTH PLAN OPTIONS (You & your Dependents must be enrolled in the same Benefit Health Plan)

CEMENT MASONS DIRECT PAYMENT PLAN

KAISER PERMANENTE IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #: _____

DEPENDENT INFORMATION (List all eligible dependents; use reverse side if you need more space)

RELATIONSHIP	GENDER	FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM PARTICIPANT)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				
CHILD	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				

I apply for health plan membership. I certify under penalty of perjury, under the laws of California that the information given in this form is true, correct, and complete to the best of my knowledge.

DATE: _____ PARTICIPANT'S SIGNATURE: _____

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 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.

DATE

SIGNATURE REQUIRED FOR KAISER PERMANENTE PLAN

FUND OFFICE USE ONLY (please do not write in this space)

NEW PARTICIPANT OPEN ENROLLMENT NEW DEPENDENT

COBRA - DATE OF QUALIFYING EVENT _____

REMARKS: _____

DATE: _____ BY: _____