San Francisco Culinary, Bartenders & Service Employees Trust Funds

Trust Office: 1182 Market Street Suite 320 • San Francisco CA 94102-4919
Administrative Office: 2323 Eastlake Ave E • Seattle WA 98102
Phone: (844) 492-9157

PLEASE CHECK ALL THAT APPLY	**TRUST FUND OFFICE USE ONLY**:
❑ **NEW HIRE** **CHANGE OF:** ❑ **NAME** ❑ **PLAN** ❑ **ADDRESS** ❑ **MARITAL STATUS** ❑ **ADD/DELETE DEPENDENT(S)**	**GROUP NO.** _____ **EFFECTIVE DATE OF COVERAGE:** _____

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	**EMPLOYER**	**DATE OF HIRE (MM/DD/YYYY)**
☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED**		

Ethnicity _____ **Preferred Language** _____

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

CHOICE OF MEDICAL PLANS:
- ☐ **BLUE SHIELD OF CA**
- ☐ **CCHP - Plan A**
- ☐ **DIRECT-PAY**
- ☐ **KAISER – Group #14-0**

CHOICE OF DENTAL PLANS:
- ☐ **DELTA DENTAL**
- ☐ **INTERDENT DENTAL (NAISMITH)**
- ☐ **UNITED HEALTHCARE (PUD)**

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
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO
Dependent*						❑ YES ❑ NO	❑ YES ❑ NO

*** Attach copies of Registered 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.**

With my signature, under penalty of perjury under state and federal law, I hereby certify that the information provided in this enrollment form is true and correct.

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

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 Name: _____	Receiving Part A? Yes ☐ No ☐ If yes, effective date: _____/_____/_____ Receiving Part B? Yes ☐ No ☐ If yes, effective date: _____/_____/_____
Please list the individual receiving Medicare Name: _____	Receiving Part A? Yes ☐ No ☐ If yes, effective date: _____/_____/_____ 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 Name: _____	Receiving Kidney Transplant? Yes ☐ No ☐ If yes, date of Transplant: _____/_____/_____ Receiving Dialysis? Yes ☐ No ☐ If yes, date of Transplant: _____/_____/_____

Blue Shield HMO Provider Information: Blue Shield of California directory website; www.blueshieldca.com/fap/app/search.html		
PARTICIPANT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
SPOUSE/DOMESTIC PARTNER NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number :______________________	IPA/Medical Group number: :______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number:______________________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP): ______________________	
Provider number:______________________	IPA/Medical Group number: :______________________	Existing patient? ☐YES ☐NO

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.

Blue Shield of California Authorization: The following authorization section is to be signed by **all** employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"). **This enrollment cannot be processed without your signed authorization.**

I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan, I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled or following 30-day notice, rescinded. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/BlueShield Life.

SIGNATURE OF PARTICIPANT: ______________________________ **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 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 REQUIRED FOR ALL KAISER PERMANENTE PLANS **DATE**

Chinese Community Health Plan Disclosure of Personal and Health Information: CCHP understand the importance of keeping your and your dependents' personal and health information private. CCHP protects this information in electronic, written, and oral forms when used throughout our company. CCHP will not disclose this information without your authorization except as permitted by law. For the purpose of administering your CCHP coverage, CCHP is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, CCHP is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan or your insurance agent. A complete explanation of CCHP policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing CCHP's website.

Chinese Community Health Plan Arbitration Agreement: I understand that (except for Small Claims cases) any and all disputes, including 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), which may arise under the agreement between me and CCHP and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, 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. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

PARTICIPANT NAME:______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
SPOUSE/DOMESTIC PARTNER NAME:______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO
DEPENDENT NAME: ______________________	Name of primary care physician (PCP):______________________	
Provider number:______________	Medical Group number:______________	Existing patient? ☐YES ☐NO

SIGNATURE OF PARTICIPANT: ______________________________ **DATE:** ______/______/______