



**LABORERS HEALTH AND WELFARE TRUST FUND  
FOR NORTHERN CALIFORNIA**  
220 Campus Lane, Fairfield, CA 94534-1498  
Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530  
E-Mail Address: customerservice@norcalaborers.org  
Website: http://www.norcalaborers.org

**FUND OFFICE USE ONLY (640)**

EFF. DATE:

HCID: **LA**

ELIGIBILITY CODE/GROUP NO.:

**ACTIVE PLAN & SPECIAL PLAN APPLICATION FORM**

**EMPLOYEE INFORMATION** (Please print or type in black ink only)

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.

**LABORERS 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)

FIRST NAME AND MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM EMPLOYEE)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	IF NOW OR PREVIOUSLY KAISER MEMBER, ENTER MEDICAL RECORD #	DEPENDENT RELATIONSHIP	<b>FUND OFFICE USE ONLY</b>
1.				SPOUSE	
2.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
3.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
4.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT
5.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> STUDENT

*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.*

**I UNDERSTAND THAT EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO THE MEDICARE APPEALS PROCEDURE, OR BENEFIT-RELATED DISPUTES IN COMPLIANCE WITH ERISA, ANY CLAIM THAT I, MY HEIRS, OR OTHER CLAIMANTS ASSOCIATED WITH ME, ASSERT FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATING TO MALPRACTICE, 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 A LAWSUIT OR COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. I UNDERSTAND THAT THE FULL ARBITRATION PROVISION IS CONTAINED IN THE EVIDENCE OF COVERAGE (EOC). I AGREE TO GIVE UP MY RIGHT TO A JURY TRIAL AND ACCEPT THE USE OF BINDING ARBITRATION. Your application will not be accepted without your signature below.**

Date: \_\_\_\_\_ Participant's Signature: \_\_\_\_\_

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

NEW MEMBER  OPEN ENROLLMENT  ADD DEPENDENT  
 COBRA - DATE OF QUALIFYING EVENT \_\_\_\_\_

REMARKS:

DATE: \_\_\_\_\_ BY: \_\_\_\_\_