



**LABORERS HEALTH AND WELFARE TRUST FUND
FOR NORTHERN CALIFORNIA**
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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

EFF. DATE:

HCID: **LA**

ELIGIBILITY CODE/GROUP NO.:

RETIRED PLAN APPLICATION FORM

RETIREE INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST
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RESIDENCE ADDRESS (not Post Office Box)	CITY	STATE	ZIP CODE
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TELEPHONE NUMBER ()	LOCAL UNION	DATE OF BIRTH			SEX	MARITAL STATUS
		MONTH	DAY	YEAR	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED

ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED RETIREE? NO
 YES: PROVIDE THE DECEASED RETIREE'S SOCIAL SECURITY NUMBER:

DEPENDENT INFORMATION

List all eligible dependents to be enrolled. (See Retired Plan Benefit Application Form Instruction Sheet)

NAME OF DEPENDENT write first and middle initial (and last name if different from retiree)	DATE OF BIRTH MO / DY / YR	SOCIAL SECURITY NUMBER	(J) Primary Care Physician/PMG or Medical Record #	DEPENDENT RELATIONSHIP
1.				SPOUSE
2.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
3.				<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

LIST ANY ADDITIONAL ELIGIBLE DEPENDENTS ON A BLANK SHEET OF PAPER AND INCLUDE ALL THE INFORMATION ABOVE FOR EACH. INCLUDE THE EXTRA SHEET WHEN MAILING THE APPLICATION TO THE FUND OFFICE.

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER INSURANCE? NO
 YES: PROVIDE NAME OF THE INSURANCE COMPANY:

BENEFIT HEALTH PLAN OPTIONS FOR PARTICIPANTS WHO ARE NOT ELIGIBLE FOR MEDICARE

Please check only one box. (See Retired Plan Benefit Application Form Instruction Sheet)

A HEALTH NET REGULAR PLAN
PARTICIPATING MEDICAL GROUP NUMBER: _____
NAME OF PRIMARY CARE PHYSICIAN: _____

B KAISER (IF NOW OR A FORMER KAISER MEMBER, ENTER MEDICAL RECORD #: _____)
IMPORTANT: If you elect Kaiser, you should be aware that you will have to elect another plan effective March 1, 2009 as Kaiser will no longer be an optional plan.

C PACIFICARE HEALTH PLAN
NAME OF PRIMARY CARE PHYSICIAN: _____
NAME OF PARTICIPATING MEDICAL GROUP: _____



D LABORERS DIRECT PAYMENT PLAN

BENEFIT HEALTH PLAN OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS

Please check only one box. (See Retired Plan Benefit Application Form Instruction Sheet)

Please read the following important notice before making an election. The Plan's term "Eligible for Medicare" means an individual who is qualified to enroll in both Federal Medicare Parts A and B whether or not the individual has actually enrolled for Medicare. If you are an "Eligible for Medicare" individual who did not enroll in both Medicare Parts A and B:

(1) you cannot elect any of the HMOs' Medicare Plans below as they require the individual to be enrolled in both Parts A and B; but you can elect the Non-Medicare Plan on the front page of this application.

(2) if you elect the Laborers Managed Health Care Plan, the Plan will charge you the Medicare premium rate whether or not you enrolled in Medicare Part B, and, will estimate the benefits payable under Medicare when your claims are paid.

After you file this application, it is your obligation to notify the Fund Office immediately of any changes to your Medicare enrollment status. Please answer the following questions and make your Plan election below:

YOUR Medicare effective date

PART A: MONTH: _____ YEAR: _____

PART B: MONTH: _____ YEAR: _____

PART D: MONTH: _____ YEAR: _____

Your SPOUSE Medicare effective date

PART A: MONTH: _____ YEAR: _____

PART B: MONTH: _____ YEAR: _____

PART D: MONTH: _____ YEAR: _____

**HEALTH NET REGULAR PLAN
(YOU CANNOT ELECT THIS PLAN IF YOU LIVE IN HEALTH NET SENIORITY PLUS PLAN)**

E PARTICIPATING MEDICAL GROUP NUMBER: _____
NAME OF PRIMARY CARE PHYSICIAN: _____

HEALTH NET SENIORITY PLUS

F PARTICIPATING MEDICAL GROUP NUMBER: _____
NAME OF PRIMARY CARE PHYSICIAN: _____

KAISER PERMANENTE SENIOR ADVANTAGE

G IMPORTANT: If you elect Kaiser, you should be aware that you will have to elect another plan effective March 1, 2009 as Kaiser will no longer be an optional plan.

PACIFICARE SECURE HORIZONS HEALTH PLAN

H NAME OF PRIMARY CARE PHYSICIAN: _____
NAME OF PARTICIPATING MEDICAL GROUP: _____

I LABORERS DIRECT PAYMENT PLAN

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: _____ RETIREE'S SIGNATURE: _____

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

<input type="checkbox"/> NEW RETIREE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> DELETE DEPENDENT	<input type="checkbox"/> COBRA DATE OF QUALIFYING EVENT _____	REMARKS: _____ _____ DATE: _____ BY: _____
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RETIRED PLAN BENEFIT APPLICATION FORM INSTRUCTION SHEET

IMPORTANT: *You and your Eligible Dependents must be enrolled with the same Benefit Plan Provider.* For example, if the Retiree is Medicare eligible and selects Health Net Seniority Plus (box **F** is checked) and his spouse is Non-Medicare, she must select Health Net Regular Plan (box **A** is checked). She cannot select Kaiser, PacifiCare or the Laborers Managed Health Care Plan.

PARTICIPANTS WHO ARE NOT ELIGIBLE FOR MEDICARE

Item A If you want the **Health Net Plan**, check this box and write in your Primary Care Physician's name and Participating Medical Group (PMG) number.

Item B If you want **Kaiser Permanente**, check this box. **IMPORTANT: If you elect Kaiser, you should be aware that you will have to elect another plan effective March 1, 2009 as Kaiser will no longer be an optional plan.**

- Enter your Medical Record Number if you currently belong to Kaiser Permanente.

Item C If you want the **PacifiCare Health Plan**, check this box and write in your Primary Care Physician's name and Participating Medical Group's (PMG) name.

Item D If you want the **Laborers Direct Payment Plan**, check this box.

MEDICARE-ELIGIBLE PARTICIPANTS ONLY

IMPORTANT: A copy of your Medicare Card (with Parts A & B) is required. If both you and your Spouse are eligible for Medicare and you want to enroll in the same Plan, check one box labeled **E** through **I**. Note that under **Health Net**, two different Plans are available for Medicare eligible Retirees. For example, you can select **Health Net Regular Plan** (box **E**) and your Spouse can select **Health Net Seniority Plus** (box **F**). **If you check box F, G or H, you must also complete the HMO's application form for each person wishing to enroll in that Plan.**

Item E If you want the **Health Net Regular Plan**, check this box and write in your Primary Care Physician's name and Participating Medical Group (PMG) number. **YOU CANNOT ELECT THIS PLAN IF YOU LIVE IN HEALTH NET SENIORITY PLUS PLAN.**

Item F If you want the **Health Net Seniority Plus Plan**, check this box and write in your Primary Care Physician's name and Participating Medical Group (PMG) number.

Item G If you want the **Kaiser Permanente Senior Advantage Plan**, check this box. **IMPORTANT: If you elect Kaiser, you should be aware that you will have to elect another plan effective March 1, 2009 as Kaiser will no longer be an optional plan.**

Item H If you want the **PacifiCare Secure Horizons Health Plan**, check this box and write in your Primary Care Physician's name and Participating Medical Group's (PMG) name.

Item I If you want the **Laborers Direct Payment Plan**, check this box.

DEPENDENTS PRIMARY CARE PHYSICIAN / PMG

Item J If you selected the **Health Net Regular, Health Net Seniority Plus, PacifiCare or PacifiCare Secure Horizons Plans** and any member(s) of your family selected a Primary Care Physician and Participating Medical Group (PMG) which is different from the one you selected, write each dependent's Primary Care Physician's name and Participating Medical Group's (PMG) name or number here.

If you selected the ***Kaiser Permanente*** or the ***Kaiser Permanente Senior Advantage Plan*** and any member of your family currently belongs to Kaiser Permanente, write your Medical Record Number here.