NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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BLUE SHIELD OF CALIFORNIA PPO / HMO *SURVIVING DEPENDENT* ENROLLMENT/CHANGE FORM ("FORM")

You must complete numbers 1 through 15 in blue or black ink. Form may be considered invalid if it: (a) is not completed in full or (b) contains any type of alterations (e.g. correction tape, white out, etc.). Invalid Forms will be returned to you for completion prior to processing. Read instructions on reverse side prior to completing this Form.

IMPORTANT NOTE – DO NOT DELAY: Full completion and return of this Form is mandatory for all Participants for enrollment, changes, and upon request by the Trust Fund Office. For any Dependents listed on the Form, legal documentation establishing the Participant's relationship to the Dependent (e.g. certified birth certificate, certified marriage certificate, etc.) needs to be on file with the Trust Fund Office. If you have not already submitted such documentation for any Dependent listed on this Form, you should attach a copy when you submit the completed Form.

SURVIVING DEPENDENT INFORMATION

1. Last Name, include Suffix (if applicable)	2. First Name	3. M.I.	4. Sex	5. Date of Birth	6. Social Security Number
			❑ M ❑ F	/ /	- -

7. Mailing/Residence Address **City** **State** **Zip Code**

8. Marital Status

❑ Widowed
❑ Married
❑ Never Married
❑ Widowed and Remarried

Applicable Date of Current Marital Status:

_____/_____
Month **Year**

9. Are you Eligible for Medicare?

❑ Yes ❑ No

If yes complete the following, and attach a copy of your Medicare Card

Part A ❑ Part B ❑

Effective Date(s) _____/_____
Month **Year**

10. Surviving Dependent's

Primary Phone ( ) -

Secondary Phone ( ) -

Email Address:_____

HEALTH PLAN SELECTION

Your Selection is for your entire family. Please check one box only. Important: You may only enroll and maintain enrollment in the Blue Shield of California HMO Plan if neither you nor any of your Dependents are Medicare eligible. If you are enrolled/enrolling in the Blue Shield of California HMO Plan, you must designate a Primary Care Physician (PCP) and an IPA/Medical Group. If you fail to complete this section, Blue Shield will automatically assign you to a PCP/IPA Medical Group. You will be required to schedule appointments/services through your PCP/IPA Medical Group. To enroll in the Blue Shield HMO Plan, the Surviving Dependent and all of their eligible Dependents must reside in a service area provided for under the Blue Shield of California HMO Plan.

11.	❑ Blue Shield of California PPO Plan (Nationwide coverage)	**or**	❑ Blue Shield of California HMO Plan (Limited coverage area in California) PCP (Primary/Personal Care Physician):_____ IPA/Medical Group Name:_____

DEPENDENT CHILD INFORMATION

When completing this Form, ALL Dependents eligible to be enrolled and maintained in the Plan must be listed. Failure to list any/all eligible Dependents on the Form will result in termination of their Health and Welfare coverage. Refer to reverse side for definitions of eligible Dependents.

12. Dependent Child (ONE) (Complete All Sections)

❑ Natural Child
❑ Stepchild
❑ Other - Define:

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address **City** **State** **Zip Code**

Is this Dependent Disabled?

❑ Yes ❑ No

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. Please be aware, this Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____

IPA/Medical Group Name: _____

13. Dependent Child (TWO) (Complete All Sections)

❑ Natural Child
❑ Stepchild
❑ Other - Define:

Last Name, include Suffix (if applicable)	First Name	M.I.	Sex	Date of Birth	Social Security Number
			❑ M ❑ F	/ /	- -

Address **City** **State** **Zip Code**

Is this Dependent Disabled?

❑ Yes ❑ No

Blue Shield HMO Enrollees: Complete only if you are enrolled/enrolling in the Blue Shield HMO Plan. If you fail to complete this section, Blue Shield will automatically assign this Dependent to a PCP and IPA/Medical Group. Please be aware, this Dependent will be required to schedule appointments/services through their PCP/IPA Medical Group.

PCP (Primary/Personal Care Physician): _____

IPA/Medical Group Name: _____

IMPORTANT NOTICE: I apply for Health and Welfare coverage through the Plan for myself and the person(s) listed and agree that we shall abide by the provisions of the Northern California Pipe Trades Trust Funds, Blue Shield of California, Delta Dental of California, and Vision Service Plan (VSP).

I understand that I will be liable for any claims incurred and/or premiums paid, including costs and attorneys' fees incurred, that result from inaccurate or false statement(s), enrolling or maintaining enrollment of ineligible Dependent(s), and/or failure to notify the Trust Fund Office within 30 days of any change of information listed on the Form. In addition to the applicable Agreement listed above, I also certify that I have read and understand both sides of the Form, the Enrollment Procedures and the Dependent Eligibility Definitions.

Eligibility for all persons listed on this two sided Form are subject to all provisions and limitations of the Trust Agreement and Plan Document (as amended) as well as to any rules and regulations adopted by the Board of Trustees. Please see your Summary Plan Description for details.

I acknowledge that the information provided on this Form is accurate and I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____

14. SIGNATURE OF SURVIVING DEPENDENT REQUIRED **15. DATE**

TRUST FUND OFFICE USE ONLY: ☐ Audit ☐ Change ☐ IN / OUT of CA / USA ☐ COBRA ☐ New Surviving Dependent	**EFFECTIVE DATE:**

ENROLLMENT PROCEDURES

IMPORTANT INFORMATION - Please read prior to completing the Enrollment/Change Form ("Form").

- The Form must be completed to enroll you and your Dependents, if applicable, for Health and Welfare coverage under the Northern California Pipe Trades ("NCPT") Health and Welfare Plan within 30 days from the date you become eligible or you acquire a new Dependent (e.g. marriage, birth, adoption, etc.). You are required to notify the Trust Fund Office by full completion of a new Form within 30 days of a change in life circumstances (e.g. marriage, separation, divorce, Surviving Dependent and/or Dependent Child(ren) change of address, new Dependents, Dependent status changes, etc.).
- Plan rules allow an eligible Surviving Dependent to change their Health Plan selection once in any 12 month period. However, Surviving Dependents must be eligible for Health Plan coverage and remain in the selected plan for the next 12 months, unless the Surviving Dependent moves out of the Plan's service area. If special circumstances exist, a change may be approved.
- Generally, if your fully completed Form and any Plan required documentation are received by the 20th of the month, changes will be effective the first of the month following receipt of the Form. Failure to provide Plan required documentation may cause a delay in processing any changes and/or enrollment. Contact the Trust Fund Office for additional information and/or to confirm your exact effective date(s).
- If you and/or your eligible Dependent(s) incur(red) claims prior to your anticipated effective date, contact the Trust Fund Office immediately. Retroactive coverage may be limited due to the Carriers retroactive limitations/rules.
- It is both the Surviving Dependent's and Dependent Children's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. Failure to notify the Trust Fund Office within 30 days of a Dependent's change in eligibility status may be considered fraud and could result in requests for reimbursement of any overpayments and/or loss of certain extensions of coverage for the ineligible Dependent(s). The Surviving Dependent and ineligible Dependent(s) may also be responsible for attorney's fees or other costs incurred by the Plan as a result of maintaining an ineligible Dependent(s).
- The Plan recommends that you and/or your Dependent(s) enroll in Medicare Parts A and B of the Federal program during the three (3) months before the month in which you and/or your Dependent(s) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. Moreover, if you and/or your Dependent(s) are under age 65 but eligible for Medicare, you and/or your Dependents must also enroll for Parts A and B. Proof of Medicare status is required to maintain your coverage and avoid penalties in premiums. Retirees and/or Dependent(s) who are Medicare eligible but fail to enroll in Medicare Parts A and/or B are subject to an additional monthly premium to help offset the additional costs imposed on the Plan for Medicare eligible individuals who elected not to enroll. The rate of this additional premium is determined by the Board of Trustees and will likely increase in the future.

DEPENDENT CHILDREN ELIGIBILITY DEFINITIONS If you are eligible for Retiree Health and Welfare coverage, the following Dependents may be covered:	**PLAN REQUIRED DOCUMENTS** **FOR ENROLLMENT:**	**FOR TERMINATION:**
CHILDREN THROUGH 25 YEARS OF AGE MAY INCLUDE THE DECEASED PARTICIPANT'S: • **Natural Children.** • **Stepchildren** who were enrolled in the Plan prior to the Participant's death. • **Legally Adopted Children.** • **Children for whom the Participant had been Appointed Legal Guardian.**	Updated Form, copy of Certified Birth Certificate and, if applicable, legally recognized documentation establishing custody and responsibility for health coverage (e.g. court order).	Updated Form. Contact the Trust Fund Office.
UNMARRIED PERMANENTLY DISABLED NATURAL CHILDREN OF THE DECEASED PARTICIPANT whose coverage would otherwise terminate due to attainment of age 26 may continue to be eligible, providing the Dependent meets Plan rules as outlined in the Summary Plan Description and any subsequent Summary of Material Modifications to the Plan.	Contact the Trust Fund Office.	Contact the Trust Fund Office.

HOW TO COMPLETE THE FORM

- Complete numbers 1 through 10 with the information of the Deceased Participant's Surviving Dependent.
- Choose a Health Plan Selection in number 11. Your eligible Dependent(s) will be enrolled in the same Health Plan.
- Complete number 12 through 13 (if applicable) and provide the Plan required documents. You MUST fully complete all subsections. **Attach additional Form(s) to enroll additional Dependents.**
- Read the **Blue Shield of California Agreement** and **IMPORTANT NOTICE** above the signature line before you complete numbers 14 and 15.
- If you and/or any Dependent(s) have **Medicare, submit a copy of the card(s) with this Form.**

DISENROLLMENT PROCEDURES

If you wish to dis-enroll yourself and/or your eligible Dependent(s), a written request must be submitted to the Trust Fund Office.

If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Trust Fund Office.

If you are eligible for Medicare Benefits you must contact the Trust Fund Office for the required forms.

IMPORTANT: BECAUSE MEDICARE REQUIRES TIME TO PROCESS YOUR DISENROLLMENT REQUEST, FAILURE TO DISENROLL TIMELY MAY RESULT IN A LAPSE IN UTILIZING YOUR MEDICARE BENEFITS.

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