Employee Enrollment Form **MULTI UNION SECURITY TRUST FUND** 531

EMPLOYEE INFORMATION (Please type or print clearly. Use black ink.)

EMPLOYER NAME	UNIT NO.	DIVISION	EFFECTIVE DATE
	1350-		

SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	MI

ADDRESS (NO PO BOX)	CITY	STATE	ZIP	PHONE

DATE OF BIRTH	SEX	MARRIED	DATE OF HIRE	UNION ☐Yes ☐No	UNION LOCAL

YOU ARE ENROLLING IN THE BENEFITS LISTED BELOW

Medical	Dental	Vision
Anthem Blue Cross $10/$100	DHS DHMO	Davis

LIFE INSURANCE BENEFICIARY DESIGNATION

The benefits payable under the Trust Fund will be paid to your beneficiary or beneficiaries according to this designation or in the order of preference rules established by the Trust. Refer to your summary plan description for these preference rules. PRINT carefully the full Name and Relationship. If you wish beneficiaries to share benefits, designate the percentage or dollar amount of benefit you wish each to receive. The percentage given must equal 100% of the total amount of the benefit.

LIFE AMOUNT: $50,000

BENEFICIARY	RELATIONSHIP	PERCENTAGE
BENEFICIARY	RELATIONSHIP	PERCENTAGE
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I UNDERSTAND THAT THESE CHANGES CANCEL ALL PREVIOUS BENEFICIARY DESIGNATIONS

PRIMARY CARE PHYSICIAN SELECTION

PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MEDICAL GROUP NUMBER	PROVIDER NUMBER

DENTAL COVERAGE (If Applicable)

DENTIST NAME OR DENTAL OFFICE	PARTICIPATING DENTAL NUMBER

FAMILY INFORMATION

List below the dependents you wish to enroll and a Primary Care Physician if it is different.

Your Dependent's Social Security Number is required by Federal Law

SPOUSE

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

SPOUSE SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

Please Sign Authorization, Acknowledgment and Disclosure on reverse side

Employee Enrollment Form (Continued)

FAMILY INFORMATION

List below the dependents you wish to enroll and a Primary Care Physician if it is different.

Your Dependent's Social Security Number is required by Federal Law

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

CHILD

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

FIRST NAME	MI.	LAST NAME	DATE OF BIRTH	SEX

CHILD SOCIAL SECURITY NO	PRIMARY CARE PHYSICIAN	EXISTING PATIENT (Y/N)	MED. GROUP/PCP NUMBER

AUTHORIZATION, ACKNOWLEDGEMENT AND DISCLOSURE OF PERSONAL INFORMATION

The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, section 56 et seq. of the California Civil Code. Your cooperation is requested.

Authorization to obtain or release medical information: I hereby authorize my physician, healthcare practitioners, hospital, clinic or other medically related facility to furnish to the Health Plan selected above, or its representatives or designee, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal (including the release to an independent review organization) or grievance, or for preventative health or health management purposes.

I authorize the Health Plan selected above, or its representative or designee, to disclose to the hospital or healthcare service plan, self-insurer, any such medical information obtained in such disclosure if necessary to allow the processing of any claim.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and the Health Plan selected above, any affiliated companies, or any Participating Physician Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

SIGNATURE OF EMPLOYEE ______________________ DATE ____________