UDWA / AFSCME Local 3930
Insurance Trust Office
940 Calle Negocio #110
San Clemente, CA 92673
800-883-0902 Toll Free
949-545-0167 Fax

NOTE: To enroll you must complete this form sign the application and return in the envelope provided

Orange County UDWA Local 3930 Enrollment Application

Group # - Kaiser Permanente – 227397-0000 / DHS – 5045H

EMPLOYEE/SUBSCRIBER INFORMATION

___ - ___ - ___ Social Security Number | Last Name | First Name | Middle

___ / ___ / ___ Date of Birth

Gender: □ Male □ Female

Marital Status: □ Married □ Single

Preferred Language Spoken | Preferred Language Written | E-mail Address

Street Address | City | State | Zip Code

( ) Day Phone

( ) Evening Phone

_____ Primary Dentist Selection - See included dental directory - Enter dentist code above. Code is the 4 digits before the dentist name

Benefit Deduction Authorization

In the event payroll deductions cease, I authorize UDW's third-party processor to initiate a monthly recurring, automatic funds transfer with my financial institution to which my pay is deposited by my Employer in an amount equal to the monthly co-contribution premium I am required to pay in order to remain enrolled in the plan of Health and Welfare benefits I have selected. My current co-contribution premium is $30 per month, however this amount may change from time to time and, if so, this authorization will remain effective for any such amounts. I understand that this service is available to me as a result of my UDW membership, and if I should cease to be a member of UDW I will no longer be provided this service and the automatic deductions and payment of my premiums will cease.

Adjusting entries to correct errors is also authorized. I agree that withdrawals and adjustments to my checking or savings accounts may be made electronically and under the Rules of the National Automated Clearing House Association. My UDW membership card authorizes my Employer/State Controller to provide to UDW's payment processor my bank account information, which authorization shall also apply to for purposes of payment of my Health & Welfare premiums.

I understand that this authorization is not an indication or guarantee of enrollment or eligibility in the plan. I further understand that it is my sole responsibility to ensure my co-contribution premiums are timely made to the plan, to ensure that sufficient funds are available in my account to process on my behalf payment of premiums under this authorization, and to ensure my account information remains current and accurate.

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.

SIGN HERE →

Signature Required **Date**