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: You must complete this form, sign the application and return in the envelope provided for enrollment

Orange County UDWA Local 3930 Enrollment Application

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 (optional)

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

ACCEPTANCE OF COVERAGE

- **I understand the total cost to me for the Kaiser Permanente medical plan and the DHS dental plan is $30.00 per month. This $30 will be deducted from my State of California issued paycheck. If a deduction is missed you will be invoiced and must pay that invoice to keep your insurance.**
- **I understand that I must continue to work 80 or more paid hours each month to keep the insurance**

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 for Kaiser Permanente Plan **Date**

TO BE COMPLETED BY EMPLOYER (FOR OFFICE USE ONLY)

Orange UDWA Local 3930 Company Name | ***227397-0000*** Group Number | Effective Date

Enrollment Reason: □ New Hire □ Loss of Other Coverage □ Open Enrollment □ Other: Reached Top of Waitlist Event Date: _____ Date of Hire: _____

Wait List Number:

UDW The Homecare Providers Union

United Domestic Workers of America
AFSCME Local 3930 /AFL-CIO

ORANGE COUNTY HEALTH INSURANCE QUESTIONNAIRE

(This form must be returned with your enrollment forms to be enrolled)

YOUR NAME (as if appears on your state payroll check):

_____

SOCIAL SECURITY NUMBER: _____

AUTHORIZED HOURS PER MONTH FOR ALL CLIENTS: _____

DATE OF HIRE FOR FIRST CLIENT: _____

SIGNATURE: _____

PLEASE CHECK ALL OF THE FOLLOWING (if they apply):

☐ I am currently working a minimum of 80 hours per month and I understand that I must maintain minimum working hours of 80 paid hours per month to remain eligible for health insurance

☐ I understand and agree to pay through payroll deduction or by invoice $30.00 per month premium co-pay for my health insurance and failure to do so may result in losing health benefits

Please note: The UDW does not want any member to lose health insurance benefits. If you have problems paying your co-pay, let us know immediately to see if we can work something out for you. If your hours drop below 80 because of your illness or your client is hospitalized, etc., let us know immediately. Call our Orange Co. Trust Administration office at (800)-883-0902 – Goldman & Walker Insurance Services, LLC.

RETURN THIS QUESIONNAIRE AND ENROLLMENT FORM IN THE SELF ADDRESSED ENVELOPE MAIL ASAP AS WE ARE CURRENTLY RUNNING A WAITING LIST FOR YOUR HEALTH BENEFITS

Orange County Trust Administration Office: 940 Calle Negocio • Suite 110 • San Clemente, CA 92673
Tel. Toll Free (800) 883-0902 • Fax: (949) 545-0167 • E-mail: gwalker@goldmanwalker.com