California Region Group Enrollment

To enroll please complete this application & the questionnaire on the back

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name **UDW San Diego Provider Union Health Benefits** Hire date (mm/dd/yyyy) N/A

Group number **228586** Enrollment unit 7003 or 7004 Effective enrollment/ change date (mm/dd/yyyy) N/A

A. ENROLLMENT/CHANGE REASON *(see Change Table for assistance)* New group: ❑ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D*

Health Plan *(Check one)* ❑ HMO Plan ❑ Deductible Plan

Please select one option: HMO or Deductible

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* _____

❑ Name change *(complete sections A, B, C, D)* From: _____ To: _____

Event Date (mm/dd/yyyy) N/A

B. EMPLOYEE Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* Social Security No.

Name (Last, First, MI) Birth Date (mm/dd/yyyy) Gender ❑ M ❑ F

Home Address City State ZIP

Work Phone Home Phone E-mail

Ethnicity Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner Spouse/domestic partner name: Former last name *(if any)*:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, 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*.

Employee/Applicant signature Date	Employer signature Date
Sign Here➡	N/A

*Additional documentation may be required.

KAISER PERMANENTE®

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UDW The Homecare Providers Union

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

SAN DIEGO MEDICAL 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 medical insurance

☐ I understand and agree to pay through payroll deduction or by invoice a $72.22 or $41.62 (depending upon what medical plan I choose) monthly premium co-pay for my medical insurance and failure to do so will result in losing medical benefits. You will be canceled from the medical benefits if you have one un-paid invoice for more than 30 days.

Please note: If your hours drop below 80 hours worked per month because of your illness or your client is hospitalized, etc., please let us know immediately. Call our San Diego County Trust Administration office at (800)-883-0902 – Goldman & Walker Insurance Services, LLC.

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

San Diego 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