OPEN ENROLLMENT FORM

2020-2021 PLAN YEAR
TEAMSTERS LOCAL 1932 HEALTH AND WELFARE TRUST

Teamsters Trust Fund Administrative Office:
433 N. Sierra Way, San Bernardino, CA 92419-4831
P 909-494-2916 | P 866-484-1337 | Fax 909-789-1311

Mailing Address:
P.O. Box 571
San Bernardino, CA 92402-0571

SECTION 1: EMPLOYEE INFORMATION

Employee ID	Last Name, First Name, Middle Initial	☐ Male ☐ Female	Date of Birth / /	Social Security Number
Home Address	City	State	Zip Code	Telephone ( )
Mailing Address ☐ Same as Home Address	City	State	Zip Code	
County of San Bernardino - Department	Email Address			

SECTION 2: ENROLLMENT DECISION - TEAMSTERS LOCAL 1932 HEALTH PLAN (Select only ONE of the following options)

☐ **I "Elect to Enroll" in Teamsters Local 1932 Health and Welfare Trust.**

☐ **I "Decline to Enroll" in Teamsters Local 1932 Health and Welfare Trust.**

In electing to "Decline to Enroll", I understand that I will be enrolled in the County of San Bernardino Employer Plan. **Go directly to the Section 10.**

SECTION 3: ELECT TO CONTINUE WITH COUNTY-ENROLLED COVERAGES (Select only ONE of the following options)

☐ **Continue with the Same Health & Dental Coverages with No Dependent Enrollment Changes Go directly to the Section 10.**

☐ **Change Coverage and/or Add Dependent(s)** Complete All Sections including Employee Signature Sections.

SECTION 4: ELECT MEDICAL AND DENTAL COVERAGE | SELECT ONE : ☐ Pre-Tax or ☐ Post-Tax

BLUE SHIELD HMO	KAISER HMO	BLUE SHIELD PPO	OPT-OUT/WAIVER
☐ **HMO Platinum Plan** **$10 copay** $0/admit; no charge Network: Access+	☐ **HMO Platinum Plan** **$10 copay** $0/admit; no charge	☐ **PPO Non-Needles**	☐ **Medical Opt-Out/Waiver****
☐ **HMO Gold Access+ Plan** **$40 copay** $100/admit; plus 20% $3,500 copay max Cal-yr Network: Access+	☐ **HMO Gold Plan** **$40 copay** $100/admit; plus 20% $3,500 copay max Cal-yr	☐ **PPO Needles**	
☐ **HMO Gold Trio Plan** **$20 copay** $100/admit; plus 20% $3,500 copay max Cal-yr Network: Trio			

SECTION 5: ELECT MEDICAL AND DENTAL COVERAGE (Continued)

DELTA DENTAL	OPT-OUT/WAIVER
☐ Delta DHMO* ☐ Delta PPO	☐ Dental Opt-Out/Waiver**

***Delta DHMO enrollees will continue with your current Delta-assigned Dentist. Contact Delta Dental to change Dentist.**

****Employees selecting to Opt-Out/Waiver of Medical and/or Dental Coverage are required to submit a completed & signed "Opt-Out/Waiver" Form; the Opt-Out/Waiver Form must be submitted, with all required documents as listed on the Form, to the Trust Administrative Office for Review and Approval/Deny Decision.**

SECTION 6: EMPLOYEE ENROLLMENT

Last Name, First Name, Middle Initial			Marital Status ☐ Single ☐ Married ☐ Domestic Partner	
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#	Existing Patient? ☐ Yes ☐ No

SECTION 7: DEPENDENT ENROLLMENT

List all dependents to be covered; dependent verification documentation is required for all dependents.
Provide the Social Security Number of each dependent you enroll.
Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.

SPOUSE/DOMESTIC PARTNER:

Relationship ☐ Spouse ☐ D.Ptnr	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth / /	Social Security Number
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No

CHILD(REN) / STEPCHILD(REN):

Relationship ☐ Child ☐ Stepchild	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth / /	Social Security Number
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No
Relationship ☐ Child ☐ Stepchild	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth / /	Social Security Number
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No
Relationship ☐ Child ☐ Stepchild	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth / /	Social Security Number
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No
Relationship ☐ Child ☐ Stepchild	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth / /	Social Security Number
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No

SECTION 8: DEPENDENT ENROLLMENT (Continued)

CHILD(REN) / STEPCHILD(REN):

Relationship	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth	Social Security Number
☐ Child ☐ Stepchild				/ /	
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No

Relationship	Last Name, First Name, Middle Initial		☐ Male ☐ Female	Date of Birth	Social Security Number
☐ Child ☐ Stepchild				/ /	
BLUE SHIELD HMO ENROLLEES ONLY	Med. Group Name	Physician Name	Physician PCP ID#		Existing Patient? ☐ Yes ☐ No

If you have more dependents to enroll, print out additional copy(ies) of **page 2** and attach to your form.

SECTION 9: NEEDLES PLAN ENROLLMENT - COUNTY OF SAN BERNARDINO, NEEDLES SUBSIDY ELIGIBLE

I understand that Needles Plan Enrollment Eligibility and the County of San Bernardino "Needles Subsidy" are entirely contingent on my work-assignment to Needles, Trona, or Baker as my work location. I understand that it is my responsibility to notify both the Trust Administrator and the County Human Resources Department - Employee Benefits and Services Division (HR-EBSD) should my assigned work-location change to an area other than Needles, Trona, or Baker.

I further understand that should it be discovered that the Needles Subsidy has been paid to me in error, the Employer (County of San Bernardino) may collect, through payroll deduction, any amount of subsidy for which I received and was not eligible.

SECTION 10: 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 the Health Plan and Dental Plan selected above, 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 the 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*.

Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.

I have read and made the appropriate corrections and changes to the information on file with the Teamsters Local 1932 Health and Welfare Trust Administrative Office.

Employee Signature	Date
	/ /