Restaurant Industry Health & Welfare Fund

Purchaser ID / Company Name:	Enrollment Unit:	Benefit Effective Date:

EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	□ Male □ Female
Address:	Apt #:	City:	State: Zip:
Date of Hire: (MM/DD/YY)	Home PH#:	Work PH#:	E-Mail Address:
Date of Birth (MM/DD/YY):	Social Security #:	Job Title:	Salary:
Marital Status: □ Single □ Married □ Domestic Partner		If available, I would prefer to receive plan information and communication in Spanish: □ Yes □ No	

Reason for Application:

☐ New Hire ☐ Open Enrollment ☐ Loss of prior coverage Date:_____

☐ Re-Hire Date:_____ ☐ Part-time to Full-Time Employment Date:_____

☐ Family Addition/ Change:_____ Qualifying Event:_____Qualifying event date:_____

☐ COBRA: ☐ 18 Months ☐ 29 Months ☐ 36 Months
Start Date:_____ End Date:_____COBRA Event:_____COBRA Event Date:_____

If there is other Health Coverage, please list family member, carrier name/group number and effective date

Name	Relation to you	Carrier Name	Group #	Effective Date	Primary
					□ Yes □ No
					□ Yes □ No

PRIOR COVERAGE (PPO PLANS ONLY): fill out the following information to receive proper credit for previous coverage.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage

DEPENDENT INFORMATION

Relation	Coverage	NAME (Last, First MI)	SSN	Gender	Date of Birth	Medical HMO: Provider #	Medical HMO: Current PCP	Dental HMO: Provider #	If children are age 26 or over you must check the appropriate boxes below
Self	☐ Medical ☐ Dental ☐ Vision	Same as above	Same as above	Same as above	Same as above		□ Yes □ No		
□ Spouse □ Domestc Partner	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			□ Yes □ No		IRS Qualified Dependent
Child	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			□ Yes □ No		□ Yes □ No
Child	☐ Medical ☐ Dental ☐ Vision			☐ F ☐ M			□ Yes □ No		□ Yes □ No

Employee Name: _____ **SSN** _____

MEDICAL ELECTIONS

□ **Enroll** □ **Decline**

Kaiser Permanente SoCal #231009 / NorCal #603578	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
CA Only- Traditional HMO **#2200**	□	□	□	□
CA Only- High Copay HMO **#2201**	□	□	□	□
CA Only- DHMO **#2202**	□	□	□	□
CA Only- DHMO Bronze Plan **#4390**	□	□	□	□
CA Only- DHMO HSA **#8109**	□	□	□	□
OOS- PPO **#1391**	□	□	□	□

KAISER PERMANENTE®

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

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.

_____ _____

Signature Required for Kaiser Permanente Plan **Date**

Declination Acknowledgement

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Medical
Employee	☐
Spouse	☐
Child(ren)	☐

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: _____

Print Name: _____ Date: _____

Employee Name: _____ **SSN** _____

DENTAL ELECTIONS

□ **Enroll** □ **Decline**

Guardian Group #00506233	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
HMO: CA Only DHMO **4000**	□	□	□	□
LOW: CA & Non-CA DPPO **Low VZ**	□	□	□	□
HIGH: CA & Non-CA DPPO **High PX**	□	□	□	□

Guardian Signature Requirement

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- **"California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."**

For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. The state in which you reside may have a specific state fraud warning. California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

_____ _____

Signature Required for Guardian Plan **Date**

Declination Acknowledgement

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Dental
Employee	☐
Spouse	☐
Child(ren)	☐

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: _____

Print Name: _____ Date: _____

Employee Name: _____ **SSN** _____

VISION ELECTIONS

□ **Enroll** □ **Decline**

VSP Vision Group #30025048	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Vision Plan **Low**	□	□	□	□
Vision Plan **High**	□	□	□	□

Declination Acknowledgement

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s) in the following coverage:

	Vision
Employee	☐
Spouse	☐
Child(ren)	☐

By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment Period or qualifying event.

Employee Signature: _____

Print Name: _____ Date: _____

Employee Name: **SSN**

BENEFITS AVAILABLE ONLY IF OFFERED BY YOUR EMPLOYER

BASIC LIFE AND AD&D COVERAGE – ☐ Enroll

Reliance Standard GEF-00934-0115	$250,000 Life & AD&D	$50,000 Life & AD&D	$10,000 Life & AD&D
Basic Life AD&D	☐	☐	☐

BENEFICIARY DESIGNATION

Beneficiary	Name	D.O.B.	SS#	Relationship	Address	Percent
Primary						
Primary						
Contingent						
Contingent						

☐ Other – Estate of Insured, Revocable or Irrevocable Trust, and Trustee Under Insured's Will

Reliance Standard Signature Requirement

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

Employee's/Member's Signature **Date** **Spouse's Signature** **Date**

Employee Name: **SSN**

EMPLOYEE ELECTION CONFIRMATION- SIGNATURE REQUIRED

Employee Authorization

I authorize my employer to deduct from my salary the premium amounts for the benefits I have elected. Premiums will be automatically deducted on a pre-tax basis as established under Section 125 of the IRS Code.

By checking here, I request to have my deductions taken post-tax: □

I understand that these elections cannot be changed during the plan years unless I experience a qualified life event as outlined in employer benefit plan documents. Qualified life events that may change my benefit elections must be reported to the Benefits Administration within 30 days of the event.

Employee Signature: _____

Print Name: _____ **Date:** _____