Enrollment Form Instructions

Please read these instructions carefully before completing the enrollment form.

Please complete this form to:

- Select your plan
- Update your dependents
- Update your address
- Select or update your beneficiaries

Completing the Form

This enrollment form covers all medical and dental plan options available. Please complete the form in its entirety. If you are making changes to one of your benefits but not changing other benefits (for example updating your medical coverage but keeping your dental coverage as is), please select the existing coverage for the coverage that won't change. **Once the form is complete, be sure to sign, date, and provide all requested information.** If you do not complete the enrollment form, you will be enrolled into the Anthem PPO program by default.

Once completed, please return the signed form and documentation to the Trust Fund Office at 15999 Cypress Avenue, Irwindale, CA 91706. Additional copies of this form can be obtained from the Plan Administrative Office or downloaded on the Trust Fund website at **www.smart-mtatrustfund.com**.

Adding or Removing Dependents

Eligible Dependents include:

1. Your lawful spouse or legal domestic partner
2. Your children under 26 years of age, including: stepchildren, legally adopted children, and children for whom you or your spouse is the court appointed guardian and who are not eligible to receive group health benefits through their own employer. Foster children are not included. Proof of guardianship is required.
3. Your children age 26 or older that reside with you, are dependent upon you for support, and are incapable of self- support because of mental or physical disability that existed prior to age 26. Medical certification must be submitted to the Trust Fund prior to child's 26 birthdate.

To add a dependent, complete the enrollment form and provide a copy of:

- Birth certificate if adding dependent children
- Marriage certificate or state declaration of domestic partnership if adding a spouse/legal partner
- Proof of Legal Guardianship or Decree of Adoption for court appointed and adopted children
- Social Security number for all dependents

To remove a dependent, complete the enrollment form and please submit:

- A written request
- Divorce decree or termination of domestic partnership
- Proof of other insurance

Please note: The Trust is unable to process enrollment changes if all required documentation is not included with your submission.

SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART-MTA Trust Fund

Trust Fund (only) to Complete this Section

Company Name
SMART-MTA TRUST FUND

Company Address
15999 Cypress Avenue, Irwindale, CA 91706

Source of Enrollment Change:

☐ Open Enrollment ☐ New Hire ☐ Employee Status Change

☐ Other: _____

Effective Date (mm/dd/yy) _____

Section 1: Operator's Personal Information

Last Name | First Name | MI | Suffix | Date of Hire (mm/dd/yy)

Home Phone | Mobile Phone | Email | Date of Birth (mm/dd/yy)

Home Mailing Address | Apt or Suite | City

State | Zip Code | Social Security # | Badge #

Gender

☐ Female ☐ Male ☐ Non-binary

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Domestic Partner

Employment Status

☐ Part Time ☐ Full Time ☐ Retiree ☐ COBRA

Preferred Language (optional)

☐ English ☐ Spanish ☐ Other: _____

Section 2: Type of Request

Please select all that apply:

☐ Add dependent ☐ Remove dependent ☐ Name change ☐ Update beneficiaries ☐ Update address

Section 3: Type of Coverage

Please note that all subscribers must be on the same medical plan.

Medical Plan Selected

☐ Anthem Blue Cross (PPO) ☐ UnitedHealthCare Harmony (HMO)

☐ Kaiser Permanente (HMO) ☐ UnitedHealthCare Value (HMO)

Dental Plan Selected

☐ Delta Dental (PPO)

☐ Dental Health Services (HMO)

Section 4: Employee and Dependent Information

List yourself and any family members to be covered. Please attach additional sheets if needed.

If you are selecting a UnitedHealthCare plan, *you must provide your Primary Care Provider's (PCP) name and information. If you are not selecting a UnitedHeatlhCare plan, please skip that box.*

Employee:

Primary Care Physician (PCP) _____ Provider # _____ Existing Patient ☐ Yes ☐ No

Spouse/ Legal Domestic Partner:

Last Name _____ First Name _____ MI _____ Date of Birth (mm/dd/yy) _____

Gender ☐ Female ☐ Male ☐ Non-binary Social Security # _____ Address, if different from Employee's _____

Primary Care Physician (PCP) _____ Provider # _____ Existing Patient ☐ Yes ☐ No

Dependent 1:

Last Name _____ First Name _____ MI _____ Date of Birth (mm/dd/yy) _____

Gender ☐ Female ☐ Male ☐ Non-binary Social Security # _____ Address, if different from Employee's _____

Primary Care Physician (PCP) _____ Provider # _____ Existing Patient ☐ Yes ☐ No

Dependent 2:

Last Name _____ First Name _____ MI _____ Date of Birth (mm/dd/yy) _____

Gender ☐ Female ☐ Male ☐ Non-binary Social Security # _____ Address, if different from Employee's _____

Primary Care Physician (PCP) _____ Provider # _____ Existing Patient ☐ Yes ☐ No

Dependent 3:

Last Name _____ First Name _____ MI _____ Date of Birth (mm/dd/yy) _____

Gender ☐ Female ☐ Male ☐ Non-binary Social Security # _____ Address, if different from Employee's _____

Primary Care Physician (PCP) _____ Provider # _____ Existing Patient ☐ Yes ☐ No

Dependent 4:	Last Name	First Name	MI	Date of Birth (mm/dd/yy)

Gender

☐ Female ☐ Male ☐ Non-binary

Social Security #

Address, if different from Employee's

Primary Care Physician (PCP)

Provider #

Existing Patient

☐ Yes ☐ No

Section 5: Life Insurance Beneficiary Information

Please note that percentage amounts must equal and not exceed 100%

Full Name	Phone Number	Social Security #	Percentage
Full Name	Phone Number	Social Security #	Percentage
Full Name	Phone Number	Social Security #	Percentage
Full Name	Phone Number	Social Security #	Percentage

Section 6: Signature Required on Binding Arbitration – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as valid as the original. ***Please sign for the plan elected.***

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 if electing Kaiser Permanente)

Date (mm/dd/yyyy)

UnitedHealthCare Arbitration Agreement. I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and UnitedHealthCare of California, UnitedHealthCare or any of its parents, subsidiaries or affiliates shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Signature (Required if electing UnitedHealthCare)

Date (mm/dd/yyyy)

Please note: The UnitedHealthCare Combined Evidence of Coverage and Disclosure Form, and Directory of Participating Medical Groups is available upon request.

Section 7: Signature Required on Terms & Conditions – Read Carefully

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated and offered through my Employer, and agree to and understand the following:

1. Based upon my selections, to be bound by the UnitedHealthCare Medical, Kaiser Permanente, and/or Delta Dental Subscriber Agreement.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. UnitedHealthCare, Kaiser and/or Delta Dental, if selected, or their designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from substance use disorder treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or healthcare operations of the Agreement.
4. Any intentional misrepresentation of a material fact in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership/coverage.
5. Coverage shall not begin until acceptance of this enrollment by UnitedHealthCare, Kaiser or Delta Dental respectively. Upon acceptance of this application, UnitedHealthCare, Kaiser, and/or Delta Dental shall be bound by the terms of the Agreement, and any Amendments thereto.
6. My Dependents and I must reside in California, live or work in the selected plan's service area.
7. If my Dependents or I elected UnitedHealthCare Harmony™ HMO or Value™ HMO, we will select a Primary Care Physician within a 30-mile radius of our Primary Residence or Primary Workplace.

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that failure to disclose true and accurate information may result in the immediate termination of the benefits. I hereby authorize the release of any necessary health information on those family members who become covered for benefits to the Plan Manager by their attending physicians.

By signing below, I confirm that I desire to participate in the coverages selected above and hereby authorize my employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premiums on group insurance policies to the SMART-MTA Trust Fund. Please note that a reproduction of this authorization shall be as valid as the original.

Signature (Required) _____ **Date (mm/dd/yyyy)** _____

California law prohibits an HIV test from being required or used by health care service plans and insurance companies as a condition of obtaining coverage.

Please return the completed form and all documentation to:

SMART-MTA Trust Fund
15999 Cypress Avenue
Irwindale, CA 91706