Return this form ONLY if you are making changes to your current coverage

Southern California Drug Benefit Fund
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ENROLLMENT FORM
PLATINUM PLUS PARTICIPANTS

Check all that apply:
☐ New Hire/Initial Enrollment ☐ Change of Address ☐ Add/Delete Dependents ☐ Change Plan(s) ☐ Transfer

(If married, New Hires must submit proof of marriage)

1. PARTICIPANT (EMPLOYEE) INFORMATION (please print and use blue or black ink)

Last Name	First Name	Mid. Initial	Social Security Number

Mailing Address Street: ☐ Check if address is new	City	State	ZIP code	Date of Birth (mm/dd/yyyy)

Home phone ( )	☐ Married ☐ Single ☐ Domestic Partnership	Sex: ☐ Female ☐ Male	Date of Marriage or Domestic Partnership *(attach proof of marriage/domestic partnership)*	☐ Divorced ☐ Widowed
Mobile phone ( )				

Employer	Store #	Work Phone ( )	Date of Hire (mm/dd/yyyy)	Job Title	Employee ID	Union Local

2. DEPENDENT INFORMATION

I wish to enroll (or disenroll) the Dependents listed below. A Marriage Certificate/proof of Domestic Partnership is required (if adding spouse/domestic partner) and Birth Certificates are required for newly enrolled Dependent Children. Note: Dependent additions are allowed only during the annual Open Enrollment or if there is a special enrollment right.

☐ Spouse ☐ Domestic Partner	SSN or TIN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN or TIN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN or TIN(required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN or TIN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll

Note: To enroll more Children, please attach a separate sheet of paper.

3. PLAN SELECTION (PLAN CHANGES ARE ALLOWED ONLY DURING OPEN ENROLLMENT OR IF THERE IS A SPECIAL ENROLLMENT RIGHT)

For information about the benefits under the Indemnity Medical Plan, Kaiser, or the UHC HMO, please see the Plan Summary. You may obtain a copy from the Drug Fund's website at www.ufcwdrugtrust.org. Note: Newly eligible Participants, except for Kaiser Employees, are required to enroll in the Indemnity Medical Plan and will be eligible to enroll in an HMO plan on the 2nd annual Open Enrollment after their hire date.

☐ **I WISH TO REMAIN IN MY CURRENT MEDICAL & DENTAL PLANS – Check this box only if you are currently enrolled** for benefits under the Fund **and do not want to change medical or dental plans.**

If you are enrolling for the first time or wish to change plans, please select a medical plan and a dental plan (you and all of your dependents must have the same medical plan and the same dental plan):

☐ **INDEMNITY MEDICAL PLAN (**Anthem Blue Cross Prudent Buyer Network/BlueCard**)**
☐ **UNITED HEALTHCARE ("UHC") HMO –** I understand that I must complete and return the UHC enrollment form that will be sent to me.
☐ **KAISER PERMANENTE HMO –** I understand that I must complete and return the Kaiser enrollment form that will be sent to me.

☐ **INDEMNITY DENTAL PLAN (**through Delta Dental of California)
☐ **UNITED CONCORDIA PREPAID DENTAL PLAN**

4. OTHER COVERAGE (It is your responsibility to notify the Fund Office in writing when you or your Dependents obtain other coverage, including Medicare.)

Is other coverage available to you through another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your spouse (or domestic partner) under another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your Child(ren) under another group health plan?	☐ Yes ☐ No	Under Medicare? ☐ Part A ☐ Part B	Name of Other Insurance Company Plan/Employer	Name of Insured

5. AUTHORIZATION AND VERIFICATION

I hereby elect coverage as indicated on this form and certify that the information provided on this form is complete and correct. To the extent consistent with applicable law, I hereby authorize any medical or dental provider or other health care practitioner, hospital or other institution to furnish to the Southern California Drug Benefit Fund (the "Fund") any information required to process claims for me and my covered family members. I also authorize the Fund, its agents, designees, and representatives to disclose to any medical or dental provider, any medical or dental information required to process any claim. I understand that if I have elected coverage under the Kaiser or UHC HMO or under the United Concordia Prepaid Dental Plan, the Fund will mail me an enrollment form for each HMO that I have selected and I must complete and return an enrollment form for each HMO in order to have coverage. I understand that any dispute or controversy which may arise between me (and/or any family member enrolled hereunder) and any HMO or Prepaid Dental Plan office must be submitted to binding arbitration in lieu of a jury or court trial. I understand that completing this form does not guarantee eligibility for benefits, and that I must first establish eligibility and maintain eligibility for benefits in accordance with the rules of the Plan. I have read and received a copy of the Summary of Benefits for the Platinum Plus Plan.

Participant (Employee) Signature (unsigned and incomplete forms will be returned) Date