



# SOUTHERN CALIFORNIA DRUG BENEFIT FUND ENROLLMENT FORM -RETIREE-

2220 Hyperion Avenue  
P.O. Box 27920  
Los Angeles, CA 90027  
(323) 666-8910

- New Enrollment
- Address Change
- Notice Of Change
- Plan Change

## 1. Retiree's Information *Retiree complete this section.*

|  |  |   |   |
|--|--|---|---|
| Last Name  |  | First Name  | M.I.  |
| Social Security Number   |  | Date Of Birth (Mo. Day Yr.)   |   |
| Totally Disabled<br><input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | <input type="checkbox"/> Single<br><input type="checkbox"/> Married                   | <input type="checkbox"/> Divorced<br><input type="checkbox"/> Widowed |
| Address  |  |   |   |
| Home Telephone Number<br>( ) ( )   |  | Other Telephone Number Where You Can Be Reached — <i>Retiree or Spouse</i><br>( ) ( ) |   |
| Emergency Contact — <i>Name</i>  |  | Emergency Contact — <i>Telephone Number</i><br>( ) ( )                                |   |

## 2. Spouse's Information *Spouse or surviving spouse complete this section.*

|  |  |   |   |
|--|--|---|---|
| Last Name  |  | First Name  | M.I.  |
| Social Security Number   |  | Date Of Birth (Mo. Day Yr.)   |   |
| Totally Disabled<br><input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | <input type="checkbox"/> Single<br><input type="checkbox"/> Married                   | <input type="checkbox"/> Divorced<br><input type="checkbox"/> Widowed |
| City   |  | State   | Zip Code  |
| Home Telephone Number<br>( ) ( )   |  | Other Telephone Number Where You Can Be Reached — <i>Retiree or Spouse</i><br>( ) ( ) |   |
| Emergency Contact — <i>Name</i>  |  | Emergency Contact — <i>Telephone Number</i><br>( ) ( )                                |   |

## 3. Retiree's Medicare And Other Coverage Information

Note: it is your responsibility to notify this office in writing when you or your dependents obtain other coverage including Medicare

|  |                                      |                             |
|--|--------------------------------------|-----------------------------|
| Are you eligible for Medicare?   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are enrolled in Medicare Part A?   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are enrolled in Medicare Part B?   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are you covered by another group health Plan?  | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name Of Plan _____ Employer _____  |                                      |                             |
| Are you enrolled as an individual in a Medicare Managed Care Plan or in one provided by another employer?      | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name Of Plan _____ Employer _____  |                                      |                             |
| Are any of your family members employed in a job which makes them eligible for coverage under this Trust Fund? | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name of the family member  | Relationship                         | Social Security Number      |
| Name of the family member employer   | Employer Telephone Number<br>( ) ( ) |                             |

## 4. Spouse's Medicare And Other Coverage Information

If your spouse or dependents have other coverage available, no coverage will be provided through this Trust Fund.

|   |                                      |                             |
|---|--------------------------------------|-----------------------------|
| Are you eligible for Medicare?  | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are enrolled in Medicare Part A?  | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are enrolled in Medicare Part B?  | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Are you covered by another group health Plan?   | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name Of Plan _____ Employer _____   |                                      |                             |
| Are you enrolled as an individual in a Medicare Managed Care Plan or in one provided by another employer? | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name Of Plan _____ Employer _____   |                                      |                             |
| Are you employed in a job which makes you eligible for coverage under this Trust Fund?                    | <input type="checkbox"/> Yes         | <input type="checkbox"/> No |
| Name of the Employer  | Employer Telephone Number<br>( ) ( ) |                             |

## 5. Retiree's Medical Plan Enrollment *Please mark your selection and complete all family information. You must live in the Service Area of a Prepaid Medical Plan to be eligible for a Prepaid Medical Plan or Medicare Managed Care Plan. For Service Areas, please refer to Prepaid Medical Plan directories.*

**Select One Plan:**

|  |  |
|--|--|
| <input type="checkbox"/> Indemnity Medical Plan<br><b>Prepaid Medical Plans For Persons Not Eligible For Medicare:</b><br><input type="checkbox"/> Pacifcare<br><input type="checkbox"/> Kaiser Foundation Health Plan | <b>Prepaid Medicare Managed Care Plans:</b><br><input type="checkbox"/> Pacifcare Secure Horizons<br><input type="checkbox"/> Kaiser Permanente Senior Advantage |
|--|--|

## 6. Spouse's Medical Plan Enrollment *You must enroll in the same Medical Plan as your spouse (unless you are a surviving spouse). You must live in the Service Area of the Prepaid Medical Plan to be eligible for a Prepaid Medical Plan or Medicare Managed Care Plan. For Service Areas, please refer to Prepaid Medical Plan directories.*

**Select One Plan:**

|  |  |
|--|--|
| <input type="checkbox"/> Indemnity Medical Plan<br><b>Prepaid Medical Plans For Persons Not Eligible For Medicare:</b><br><input type="checkbox"/> Pacifcare<br><input type="checkbox"/> Kaiser Foundation Health Plan | <b>Prepaid Medicare Managed Care Plans:</b><br><input type="checkbox"/> Pacifcare Secure Horizons<br><input type="checkbox"/> Kaiser Permanente Senior Advantage |
|--|--|

## 7. List all dependents you wish to enroll. New enrollees must submit a copy of marriage certificate (if married) and birth certificates for all dependent children. If adding a spouse, a marriage certificate must be submitted. If adding a child or step-child, birth certificates must be submitted. Enter provider number code or Kaiser number for each family member.

There is a \$15.00 per month co-pay for health and welfare coverage for yourself and each of your dependents.

|   | Last Name | First Name | M.I. | Social Security Number | Provider Number | Past Or Present Kaiser Number |
|---|-----------|------------|------|------------------------|-----------------|-------------------------------|
| Retiree   |           |            |      |                        |                 |                               |
| Spouse  |           |            |      |                        |                 |                               |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                        |                 |                               |
| <input type="checkbox"/> Son<br><input type="checkbox"/> Daughter |           |            |      |                        |                 |                               |

## 8. Notice Of Change. If you are deleting a Spouse because of a divorce or death, a final decree of divorce or death certificate must be submitted. If deleting a child because of marriage, a copy of the marriage certificate must be submitted.

| Delete Dependents  | Last Name | First Name | M.I. | Social Security Number | Date Of Birth |
|--|-----------|------------|------|------------------------|---------------|
| <input type="checkbox"/> Wife <input type="checkbox"/> Husband |           |            |      |                        |               |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter |           |            |      |                        |               |

## 9. Authorization And Verification

I hereby enroll myself and the eligible members of my family in the above medical plan. I hereby authorize any medical or other health care practitioner, hospital or other institution to furnish the Southern California Drug Benefit Fund any information required to process any claim for myself or any dependent. I also authorize the Fund, its agents, designees or representatives to disclose to any medical provider or Prepaid Medical Plan any medical information required to process any claim. I understand that any dispute or controversy which may arise under the agreements between myself (or any family member enrolled hereunder) and any Prepaid Medical Plan must be submitted to binding arbitration in lieu of a jury or court trial.

If I am not enrolled in a prepaid Medicare Managed Care Plan I hereby agree to maintain the medical coverage I have selected for 12 months from the effective date of coverage, or until the next Open Enrollment.

If I am required to pay part of the cost of my Retiree medical coverage, I authorize the Southern California United Food & Commercial Workers Unions and Drug Employers Pension Fund to deduct the cost of my coverage from my monthly pension benefit, if it is adequate, and to pay this amount to the Southern California

Drug Benefit Fund. I understand that I may revoke this authorization to deduct from my pension benefit at any time, but that should I revoke the authorization prior to the expiration of a 12 month period or the next Open Enrollment period, the Benefit Fund may recover any unpaid premium from any Health and Welfare benefits otherwise payable to me, terminate my participation in the Medical Plan and take other appropriate action permitted by the law and that I must pay the Trust Fund each month for the cost of my coverage, since the Trustees have no enforceable right to my pension benefit.

CHANGE NOTICE: I hereby verify that I have requested the changes indicated and certify that all information and documentation provided is true, correct and complete. Any falsification of information on this form may result in my legal liability.

Retiree's Signature \_\_\_\_\_ Date \_\_\_\_\_