PIBT | PRINTING INDUSTRIES BENEFIT TRUST

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PIAG
ENROLLMENT/CHANGE FORM

Aetna HMO
❑ 25/30
❑ 40/50
Check one

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION

Company Name	Phone ( )	**FOR PIBT USE ONLY**	
Address		PIBT EMPLOYER GROUP #	
		COVERAGE EFFECTIVE DATE	
		CONTROL NUMBER	SUFFIX
		ACCOUNT NUMBER	PLAN NUMBER

New Enrollment ❑ Change ❑ Other ❑
Changes (*Check appropriate boxes*)
❑ Add dependent(s) - List information in Section 4
❑ Address change - Complete Section 3
❑ Name change - Complete Sections 3 and 4

Additions, Terminations or Changes of Coverage: Report all additions, terminations or changes of group coverage to Printing Industries Benefit Trust no later than the 20th day of the month in which it is effective.

SECTION 2 LIFE INSURANCE BENEFICIARY INFORMATION

Life Beneficiary (Full Name)	Address (if different)	Relationship	Must equal 100% %
Life Beneficiary (Full Name)	Address (if different)	Relationship	%

SECTION 3 EMPLOYEE INFORMATION

Last Name		First Name		M.I.	❑ Single ❑ Married *Date of Marriage*____________ ❑ Domestic Partner *Registration Date*____________
Social Security Number	Full Time Hire Date	Employment Status ❑ Salaried ❑ Hourly	Job Title		
Residence Mailing Address (Number, Street, Apartment)		City		State	Zip
Home Telephone ( )	Mobile Phone Number ( )	Have you or any of your dependents ever been a member of the plan you have selected ? ❑ Yes ❑ No			
Effective Date Requested (must be 1st of month following employer waiting period)				Occupation	

NOTE: Any dependent child age 19 or over will not be added until Section 8 of this form is completed and approved.

SECTION 4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION

Name *Last* *First* *M.I.*	*Birthdate MM/DD/YYYY*	*Sex*	*Choose a Personal Physician Name and Provider # for each person*		*Existing Patient Yes No*
Employee	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship* Self	M ❑	*IPA/Medical Group# (required field)*		
Spouse *Date of Marriage*	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship* Spouse	M ❑	*IPA/Medical Group# (required field)*		
*First dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*IPA/Medical Group# (required field)*		
*Second dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*IPA/Medical Group# (required field)*		
*Third dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*IPA/Medical Group# (required field)*		
*Fourth dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*IPA/Medical Group# (required field)*		

SECTION 5 HEALTH CARE COORDINATION

To assist our Medical Management Team in coordinating your care, please answer the following questions:

1. Is anyone listed in Section 4 above currently receiving ongoing medical care for a serious illness or condition? ❑ Yes ❑ No

If yes, who? ______________________________

2. Does anyone listed in Section 4 above require medical care for a chronic illness or condition? ❑ Yes ❑ No

If yes, who? ______________________________

SECTION 6 DISABILITY INFORMATION

1. Do you believe that you or any family member for whom you are applying for coverage would be considered totally disabled according to the definitions of disability given on the back of this application?
   ❑ Yes ❑ No If yes, who?
   Disabling Condition(s)______________________________ Date Disability Commenced ______________

SECTION 7 OTHER HEALTH INSURANCE

1. Is anyone listed in Section 4 on previous page eligible for Medicare? ❑ Yes ❑ No If yes, who? ______________________

2. Are you or have you and/or any of your eligible family members been covered by other medical coverage within the last six months?
   ❑ Yes ❑ No If yes, complete the section below. Please list all current or prior medical coverage. **Failure to provide complete information may result in significant delay of claims processing.** (Attach additional sheets if necessary)

Covered Person's Name	Policy Holder Name(s)	Insurance Company Name(s)	Type of Coverage	Policy No.	Effective Date	Termination Date
			❑ Health ❑ Other_________			
			❑ Health ❑ Other_________			

IMPORTANT

SECTION 8 FULL TIME STUDENT VERIFICATION

Any dependent age 19 or over cannot be added unless they are a full-time student. Requirements for dependent student coverage: Full-time student in an accredited institute, dependent upon employee for support, unmarried, under 25 years of age.

Dependent's Name	Birthdate	School Year

School Name	Student I.D. #	Current # of Units

School Address	City	State	Zip

Dependent's Name	Birthdate	School Year

School Name	Student I.D. #	Current # of Units

School Address	City	State	Zip

Dependent's Name	Birthdate	School Year

School Name	Student I.D. #	Current # of Units

School Address	City	State	Zip

Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and that you have read the Plan information including the information listed on pages 2, 3, & 4 of this form and understand all agreements, including your agreement to submit disputes to binding arbitration.

Employee Signature ______________________________ Date ______________

SECTION 9 ACCEPTANCE OF COVERAGE

Explanation of Authorization to Obtain or Release Medical Information: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested. **Authorization to Obtain or Release Medical Information:** I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designees or representatives of the plan you selected or Printing Industries Benefit Trust or its agents, designees or representatives, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation, or evaluation of an application or a claim. I authorize the plan you selected, Printing Industries Benefit Trust or its agents, designees or representatives, to disclose to a hospital or health care service plan, self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable the plan you selected or Printing Industries Benefit Trust or its agents, designees or representatives to process claims and benefits.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and the plan you selected, Printing Industries Benefit Trust or its agents, designees or representatives or any Participating Medical Group/ Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

SECTION 10 DISABLING CONDITIONS

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, you may be entitled to an extension of health benefits according to California Insurance Code § 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the Maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

Total disability, as it relates to the law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age.

Application for enrollment under the plan you selected will not be considered unless the Disability Information section is completed. Please answer the questions as completely as possible to avoid delay in the processing of your application.

SECTION 11 PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

I understand that the Participating Providers, if any, do not necessarily include all types, of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize that payment be made under Part B of Medicare to participating provider for medical and other services furnished me for which it pays or has paid, if applicable.

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform Printing Industries Benefit Trust and will execute such assignments, liens, or other documents which may be necessary to enable the plan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the plan, I will immediately reimburse the plan to the extent of services provided, to the extent permitted by state law.