

5800 S. Eastern Ave., Suite 400 • Los Angeles, CA 90040 • License #0747420
 Phone (323) 728-9500 • Outside Southern Cal: (800) 449-4898
 Fax (323) 722-7386 • Outside Southern Cal: (866) 559-0355
 www.piasc.org • www.piasd.org • www.vma.bz • www.piag.org

Plan Selected- Kaiser HMO	
<input type="checkbox"/> \$5 (No. Cal. Only)	<input type="checkbox"/> \$25
<input type="checkbox"/> \$10	<input type="checkbox"/> \$30
<input type="checkbox"/> \$15	<input type="checkbox"/> \$40
<input type="checkbox"/> \$20	<input type="checkbox"/> \$50
Check One	

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION		FOR PIBT USE ONLY
Company Name	Phone () ()	
Address		GROUP #
New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Changes (Check appropriate boxes) <input type="checkbox"/> Add dependent - Complete Section 4 <input type="checkbox"/> Name change - Complete Sections 3 and 4		COVERAGE EFFECTIVE DATE PIBT ACCOUNT NO.
Changes of Coverage: Report all additions or changes of group coverage to PIBT 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.	<input type="checkbox"/> Single <input type="checkbox"/> Married Date of Marriage _____ <input type="checkbox"/> Domestic Partner Registration Date _____		
Social Security Number	Full Time Hire Date	Employment Status	Job Title		
		<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly			
Residence Mailing Address (Number, Street, Apartment)		City	State	Zip	
Home Telephone () ()	Mobile Phone Number () ()	Have you or any of your dependents ever been a Kaiser member ? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any of your dependents waived Kaiser coverage in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Effective Date Requested (must be 1st of month following employer waiting period)			Occupation		

NOTE: An eligible dependent child is an employee's or spouse's child under the age of 26.

SECTION 4 EMPLOYEE/DEPENDENT ENROLLMENT INFORMATION						
Name	Birthdate	Sex				Existing Patient
<i>Last First M.I.</i>	<i>MM/DD/YYYY</i>					Yes No
<i>Employee</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<i>Self</i>					
<i>Spouse</i>	<i>Date of Marriage</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<i>Spouse</i>					
<i>First dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<input type="checkbox"/>					
<i>Second dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<input type="checkbox"/>					
<i>Third dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<input type="checkbox"/>					
<i>Fourth dependent*</i>	<i>Birthdate</i>	F <input type="checkbox"/> M <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/>
<i>SS #</i>	<i>Relationship</i>					
	<input type="checkbox"/>					

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
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			
			<input type="checkbox"/> Health <input type="checkbox"/> Other _____			

SECTION 8 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 9 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 Kaiser Plan 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.

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 10 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.

SECTION 11 SERVICE AREAS

The service area is that portion of Kern, Los Angeles, Orange, Riverside, San Bernadino, San Diego, and Ventura Counties within the following zip codes:

90000-899	92029-30	92220	92320-22	92400-99	93030-35*	93261	93539
(except	92033	92223	92324-26	92500-32	93040	93263	93543-44
90704)	92037-40	92230*	92329	92543-46	93041-44*	93268	93550-53
91000-899	92046	92234-36*	92333-37	92548	93060-61*	93276	93560-61
91901-03	92049	92240-41*	92339-41	92551-57	93062-66	93280	93563
91908-17	92051-58	92252-56*	92345-46	92562-64	93093	93285	93581-82
91921	92064-65	92258*	92350	92567	93099	93287	93584
91931-33	92067-69	92260-64*	92352	92570-72	93203	93301-09	93586
91935	92071-72	92268*	92354	92581-87	93205-06	93311-13	93590-91
91941-47	92074-75	92270*	92357-59	92595-96	93215-17	93380-90	93599
91950-51	92079	92274-78*	92369	92599	93220	93399	
91962-63	92082-85	92282*	92371-78	92600-899	93222	93501-02	
91976-80	92090-93	92284-86*	92382	93000-09*	93224-26	93504-05	
91990-91	92096	92292*	92385-86	93010-12	93238	93510	
92007-09	92100-99	92305	92391-94	93015-16	93240-41	93518-19	
92014	92201-03*	92307-08	92397	93020-21	93243	93531-32	
92018-27	92210-11*	92313-18	92399	93022*	93250-52	93534-36	

* Subscribers residing in Coachella Valley (greater Palm Springs area) and western Ventura County are required to select an Affiliated Primary Care Physician for themselves and each covered dependent. Members will be contacted after enrollment regarding Affiliated Primary Care Physician selection. **Kaiser Permanente does not service all areas. For the complete list of zip codes, visit the Kaiser website at: www.kaiserpermanente.org.**

SECTION 12 NORTHERN CALIFORNIA SERVICE AREAS

The Service Area is that portion of Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties within the following ZI P codes:

93230	93755	94203-09	94617-27	95026	95290	95441-42	95703
93232	93760-62	94211	94643	95030-33	95296-98	95444	95722
93242	93764-65	94229-30	94649	95035-38	95304	95446	95736
93601-02	93771-80	94232	94659-62	95042	95307	95448	95741-43
93604	93784	94234-37	94666	95044	95313	95450	95746-47
93606-07	93786	94239-40	94701-10	95046	95316	95452	95758-59
93609	93790-94	94243-50	94712	95050-56	95319-20	95462	95762-63
93611-14	93844	94252-54	94720	95070-71	95323	95465	95765
93616	93888	94256-59	94801-08	95101-03	95326	95471-73	95776
93618	94002-03	94261-63	94820	95106	95328-30	95476	95798-99
93623-27	94005	94267-69	94850	95108-42	95336-37	95486-87	95812-38
93630-31	94010-12	94271	94875	95148	95350-58	95492	95840-43
93637-39	94013-31	94273-74	94901	95150-61	95360-61	95602-05	95851-53
93643-46	94035	94277-80	94903-04	95164	95363	95607-21	95857
93648-54	94037-45	94282-91	94912-15	95170-73	95366-68	95623-26	95860
93656-57	94059-67	94293-99	94920	95190-94	95376-78	95628	95864-67
93660	94070-71	94301-10	94922-31	95196	95380-82	95630	95873
93662	94074	94401-09	94933	95201-13	95385-87	95632-35	95887
93666-69	94080	94497	94937-42	95215	95391	95638-41	95894
93673	94083	94501-03	94945-57	95219-20	95397	95645	95899
93675	94085-90	94506-31	94960	95227	95401-09	95648	95903
93701-12	94096	94533-53	94963-66	95230-31	95416	95650-52	95961
93714-18	94098-99	94555-66	94970-79	95234	95419	95655	
93720-22	94101-12	94567"	94998-99	95236-37	95421	95658-64	
93724-29	94114-47	94568-81	95002	95240-42	95425	95667-74	
93740-41	94150-72	94583	95008-09	95253	95430-31	95676-78	
93744-45	94175	94585-92	95011	95258	95433	95680-83	
93747	94177	94595-99	95013-15	95267	95436	95686-88	
93750	94188	94601-15	95020"	95269	95439	95690-98	

"Exception: The communities of Bells Station and Knoxville are not in our service area.