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

PIAG

Application for Kaiser Signature HMO

PIBT | PRINTING INDUSTRIES BENEFIT TRUST
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

PIAG
ENROLLMENT/CHANGE FORM

Plan Selected
Kaiser Signature HMO Plans
❑ 20/30 ❑ 40/50 ❑ 50/55
Kaiser Signature Ded. HMO Plans
❑ 600/25 ❑ 1000/30 100%
❑ 2000/40 90% ❑ HD2000/100%

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

SECTION 1 EMPLOYER TO COMPLETE THIS SECTION

Company Name	Phone ( )	**FOR PIBT USE ONLY**	
Address		GROUP #	SUB GROUP #

New Enrollment ❑ Change ❑
Changes (*Check appropriate boxes*)
❑ Add dependent - Complete Section 4
❑ Name change - Complete Sections 3 and 4

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.

COVERAGE EFFECTIVE DATE

PIBT ACCOUNT NO.

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 Kaiser member ? ❑ Yes ❑ No Have you or any of your dependents waived Kaiser coverage in the past 12 months? ❑ Yes ❑ 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 *Last First M.I.*	*Birthdate MM/DD/YYYY*	*Sex*	*Choose a Primary Care Physician Name and Provider # for each person*		*Existing Patient Yes No*
Employee	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship* Self	M ❑	*PCP ID#*	*Medical Record #*	
Spouse *Date of Marriage*	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship* Spouse	M ❑	*PCP ID#*	*Medical Record #*	
*First dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*PCP ID#*	*Medical Record #*	
*Second dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*PCP ID#*	*Medical Record #*	
*Third dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*PCP ID#*	*Medical Record #*	
*Fourth dependent**	*Birthdate*	F ❑	*First Name*	*Last Name*	❑ ❑
SS# — —	*Relationship*	M ❑	*PCP ID#*	*Medical Record #*	

Do any of your dependents above live at another address? ❑ yes ❑ no
If yes, please complete the following

Dependent Name	*Address*
Dependent Name	*Address*

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_________			

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

This list is a convenient tool used to determine if prospective members reside within Kaiser Permanente's Service Area, which is approved by the State of Georgia Office of the Commissioner of Insurance. The State requires that Kaiser Permanente define the Service Area by counties. The following counties in Georgia are included in the Metro Atlanta Service Area: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton. The following zip codes are included within the Service Area:

30002	30034	30069	30101	30141	30187	30252	30294	30326	30359	30501	31107
30003	30035	30070	30102	30142	30188	30253	30295	30327	30360	30502	31119
30004	30036	30071	30103	30143	30189	30256	30296	30328	30361	30503	31120
30005	30037	30072	30106	30144	30204	30257	30297	30329	30362	30504	31126
30006	30038	30073	30107	30145	30205	30258	30298	30330	30363	30506	31131
30007	30039	30074	30108	30146	30206	30259	30301	30331	30364	30507	31132
30008	30040	30075	30109	30148	30212	30260	30302	30332	30365	30510	31136
30009	30041	30076	30110	30150	30213	30263	30303	30333	30368	30515	31139
30010	30042	30077	30111	30151	30214	30264	30304	30334	30369	30518	31141
30011	30043	30078	30112	30152	30215	30265	30305	30336	30370	30519	31145
30012	30044	30079	30113	30153	30216	30266	30306	30337	30371	30527	31146
30013	30045	30080	30114	30154	30217	30268	30307	30338	30374	30534	31150
30014	30046	30081	30115	30156	30218	30269	30308	30339	30375	30542	31156
30015	30047	30082	30116	30157	30219	30270	30309	30340	30376	30543	31191
30016	30048	30083	30117	30160	30220	30271	30310	30341	30377	30548	31192
30017	30049	30084	30118	30161	30222	30272	30311	30342	30378	30554	31193
30018	30052	30085	30119	30168	30223	30273	30312	30343	30379	30564	31195
30019	30054	30086	30120	30169	30224	30274	30313	30344	30380	30566	31196
30021	30055	30087	30121	30170	30228	30275	30314	30345	30384	30567	31197
30022	30056	30088	30122	30171	30229	30276	30315	30346	30385	30575	31198
30023	30058	30090	30123	30175	30230	30277	30316	30347	30386	30620	31199
30024	30060	30091	30126	30176	30232	30281	30317	30348	30387	30641	31816
30025	30061	30092	30127	30177	30233	30284	30318	30349	30388	30655	31830
30026	30062	30093	30132	30178	30234	30287	30319	30350	30389	30656	39901
30028	30063	30094	30133	30179	30236	30288	30320	30353	30390	30666	
30029	30064	30095	30134	30180	30237	30289	30321	30354	30392	30680	
30030	30065	30096	30135	30182	30238	30290	30322	30355	30394	30663	
30031	30066	30097	30137	30183	30248	30291	30323	30356	30396	31064	
30032	30067	30098	30139	30184	30250	30292	30324	30357	30398	31085	
30033	30068	30099	30140	30185	30251	30293	30325	30358	30399	31106	