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 www.piasc.org • www.piasd.org • www.pinc.org • www.piag.org

|                                     |                                    |
|-------------------------------------|------------------------------------|
| <b>Plan Selected</b>                |                                    |
| <b>Kaiser Deduc HMO</b>             |                                    |
| <input type="checkbox"/> 500/10     | <input type="checkbox"/> 1500/100% |
| <input type="checkbox"/> 500/20/20% | <input type="checkbox"/> 2000/30   |
| <input type="checkbox"/> 1000/20    | <b>Check One</b>                   |

IMPORTANT PLEASE PRINT ALL SECTIONS IN BLACK INK

**SECTION 1 EMPLOYER TO COMPLETE THIS SECTION**

|   |              |                          |
|---|--------------|--------------------------|
| Company Name  | Phone<br>( ) | <b>FOR PIBT USE ONLY</b> |
| Address   |              |                          |
| New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Other <input type="checkbox"/><br>Changes (Check appropriate boxes)   |              | GROUP #                  |
| <input type="checkbox"/> Add dependent(s) - List information in Section 4<br><input type="checkbox"/> Drop employee or dependent(s) - List those being deleted in Section 4<br><input type="checkbox"/> Address change - Complete Section 3<br><input type="checkbox"/> Name change - Complete Sections 3 and 4 |              | COVERAGE EFFECTIVE DATE  |
| 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.  |              | PIBT ACCOUNT NO.         |

**SECTION 2 LIFE INSURANCE BENEFICIARY INFORMATION**

|                              |                        |              |                      |
|------------------------------|------------------------|--------------|----------------------|
| Life Beneficiary (Full Name) | Address (if different) | Relationship | Must equal 100%<br>% |
| Life Beneficiary (Full Name) | Address (if different) | Relationship | %                    |

**SECTION 3 EMPLOYEE INFORMATION**

|   |                            |   |   |                  |
|---|----------------------------|---|---|------------------|
| Last Name   | First Name                 | M.I.  | Marital Status<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married | Date of Marriage |
| Social Security Number  | Full Time Hire Date        | Employment Status<br><input type="checkbox"/> Salaried <input type="checkbox"/> Hourly  | Job Title   |                  |
| Residence Mailing Address (Number, Street, Apartment)                             |                            | City  | State   | Zip              |
| Home Telephone<br>( )   | Mobile Phone Number<br>( ) | Have you or any of your dependents ever been a Kaiser member? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>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: 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<br>Last First M.I.  | Birthdate<br>MM/DD/YYYY              | Sex  | Existing Patient<br>Yes No                        |
|--------------------------|--------------------------------------|--|---|
| <i>Employee</i>          | <i>Birthdate</i>                     | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| SS #                     | <i>Relationship</i><br><b>Self</b>   |  |   |
| <i>Spouse</i>            | Date of Marriage                     | <i>Birthdate</i>   |   |
| SS #                     | <i>Relationship</i><br><b>Spouse</b> | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <i>First dependent*</i>  | <i>Birthdate</i>                     | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| SS #                     | <i>Relationship</i>                  |  |   |
| <i>Second dependent*</i> | <i>Birthdate</i>                     | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| SS #                     | <i>Relationship</i>                  |  |   |
| <i>Third dependent*</i>  | <i>Birthdate</i>                     | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| SS #                     | <i>Relationship</i>                  |  |   |
| <i>Fourth dependent*</i> | <i>Birthdate</i>                     | F <input type="checkbox"/><br>M <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| SS #                     | <i>Relationship</i>                  |  |   |

**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<br><input type="checkbox"/> Other _____ |            |                |                  |
|                       |                       |                           | <input type="checkbox"/> Health<br><input type="checkbox"/> 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 24 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 Kaiser 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 Kaiser, 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 Kaiser 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 Kaiser, 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 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.**

**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.

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

\* 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.

|            |                                   |
|------------|-----------------------------------|
| SECTION 13 | 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 ZIP codes:

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

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