NORTHERN CALIFORNIA CARPENTERS FUNDS ENROLLMENT FORM

P.O. BOX 2380, OAKLAND, CALIFORNIA 94614 · TELEPHONE (510) 633-0333 (888) 547-2054
Email: benefitservices@carpenterfunds.com Fax: (510) 633-0215

Directions: Complete this form to initially enroll in the Plans administered by the Carpenter Funds Administrative Office or to update your existing record.

Are you: ☐ A New Employee? OR ☐ Updating Your Record?

PARTICIPANT INFORMATION

Social Security Number, UBC#, or CFAO ID#	Date of Birth (MONTH/DAY/YEAR)	
Name (Last) (First) (MI)		
Address		
Address (Line 2)	Phone Number	
City	State	Zip
Email Address for the Receipt of Mandatory Disclosures (Voluntary)*	Sex ☐ Male ☐ Female	
Would you like us to update your contact information for all records of the Carpenters Union and Apprenticeship Training Committee? ☐ Yes ☐ No		
Current or Most Recent Employer		
Are you Retired? ☐ Yes ☐ No		
Local Union	Date Joined	
Occupation	Skill Class	
Are you enrolling as a beneficiary of a deceased participant? ☐ Yes ☐ No If Yes, please provide deceased participant's Social Security Number:		

LANGUAGE OPTION

Would you like to receive Fund correspondence in Spanish? ☐ Yes ☐ No

HEALTH PLAN SELECTION

Active Participant: Please check only one option below.

☐ Indemnity Medical Plan
(Coordination of Benefits will apply)

☐ Kaiser Permanente
(Group Number: 26, 9068, 9076 or 35684)

☐ International Benefit Option

Retired Participant: Please check only one option below.

☐ Indemnity Medical Plan

☐ Kaiser Permanente
(Group Number: 26-30)

* Providing your email address for the receipt of mandatory disclosures is voluntary. If you provide your email address, mandatory disclosures will be sent via email. See "Electronic Delivery of Plan Correspondence" on Page 4 for more information about your rights and responsibilities.

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Participant's Name	**Participant's SSN, CFAO ID or UBC#**

MARITAL STATUS

☐ Single
☐ Married Date of Marriage ____________________
☐ Separated Date of Separation ____________________
☐ Divorced Date of Dissolution ____________________ Former Spouse's Name ________________________
☐ Widowed

DEPENDENTS

When adding or removing a dependent, **Certified Documentation is Required as follows:**

- Adding a Spouse: Provide a legible photocopy of your Certified Marriage Certificate.
- Adding a Domestic Partner: Complete a Domestic Partner Packet.
- Removing a Spouse: Provide a copy of your final divorce decree including the filed Marital Settlement Agreement.
- Initial enrollment of your dependent children, stepchildren, or Domestic Partner's children: Provide a legible photocopy of their Certified Birth Certificate.
- Adding Adopted children: Provide a copy of the adoption papers.
- Adding Children for whom you are the legal guardian: Provide a copy of the filed legal guardianship papers.
- If your dependent child is 19 or older and enrolled in Medicare you MUST submit a photocopy of your dependent's Medicare card.

☐ **Spouse or** ☐ **Domestic Partner**	First & Last Name	Date of Birth	Social Security Number
Sex: ☐ Male ☐ Female	Is Dependent Medicare eligible? ☐ Yes ☐ No		
Address (if different from Participant):			
City		State	Zip

Dependent Child	First & Last Name	Date of Birth	Social Security Number
Sex: ☐ Male ☐ Female	Is Dependent Medicare eligible? ☐ Yes ☐ No		
Address (if different from Participant):			
City		State	Zip

Dependent Child	First & Last Name	Date of Birth	Social Security Number
Sex: ☐ Male ☐ Female	Is Dependent Medicare eligible? ☐ Yes ☐ No		
Address (if different from Participant):			
City		State	Zip

Dependent Child	First & Last Name	Date of Birth	Social Security Number
Sex: ☐ Male ☐ Female	Is Dependent Medicare eligible? ☐ Yes ☐ No		
Address (if different from Participant):			
City		State	Zip

If you have additional dependents to add, please include their information on a separate sheet.

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Participant's Name	**Participant's SSN, CFAO ID or UBC#**

BENEFICIARIES – Complete Section A *OR* B below. It is not necessary to complete both.

If additional space is needed to list all beneficiaries, please provide the information on an additional sheet.

Note: Plan rules dictate that unless certain criteria are met, your legal spouse will be considered your Beneficiary for benefits from the Carpenters Annuity Trust Fund Trust Fund for Northern California, Carpenters Pension Trust Fund for Northern California, and Northern California Carpenters 401(k) Plan. **If you are married and name a Beneficiary other than your Spouse below for your Pension, Annuity, and/or 401(k) it may be necessary for your Spouse to complete additional paperwork to consent to that Beneficiary designation.** For more information consult the Plan Rules and Regulations or contact the Trust Fund Office at (888) 547-2054 or benefitservices@carpenterfunds.com.

Section A – Complete this section to name the same Beneficiary(ies) for all Funds you participate in.

Beneficiary's Full Name(s)		Relationship	
Date of Birth		Social Security Number	
Address			
City	State		Zip

Section B – Complete this section to name different beneficiary(ies) for the Funds you participate in.

Annuity Fund	Full Name(s)	Relationship	
	Date of Birth	Social Security Number	
	Address		
	City	State	Zip
Pension Fund	Full Name(s)	Relationship	
	Date of Birth	Social Security Number	
	Address		
	City	State	Zip
Health & Welfare	Full Name(s)	Relationship	
	Date of Birth	Social Security Number	
	Address		
	City	State	Zip
Vacation Fund	Full Name(s)	Relationship	
	Date of Birth	Social Security Number	
	Address		
	City	State	Zip
401(k) Plan	Full Name(s)	Relationship	
	Date of Birth	Social Security Number	
	Address		
	City	State	Zip

If any of the Beneficiaries you have listed in Section A or B are minors, you must provide the following: Name of Guardian (Must be someone other than yourself):		
Guardian's Address:		
City	State	Zip

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Participant's Name	**Participant's SSN, CFAO ID or UBC#**

PARTICIPANT'S SIGNATURE

I apply for health plan membership for the persons listed and agree that we shall abide by the provisions of the health maintenance organization (HMO) service agreement or Indemnity Plan regulations whichever applies. I understand that all claims, including medical malpractice claims, which arise because I or someone with a relationship to me, believe that some conduct in, or arising from my relationship with the HMO, HMO hospitals, or the HMO's medical group as a member or a patient, has caused any harm, must be submitted to binding arbitration instead of a court trial.

Kaiser Foundation Health Plan Arbitration Agreement:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

I hereby certify under penalty of perjury under the laws of the State of California, that the information given in this form is true, correct, and complete to the best of my knowledge.

Signature Date

Electronic Delivery of Plan Correspondence: Electronic materials are emailed, typically in Portable Document Format (PDF), and are identical to the paper versions you've been receiving. There is no charge for accepting materials online. You will need an internet connection and a computer with an operating system capable of receiving, accessing and displaying and either printing or storing the electronic documents received.

You should have Adobe Reader to access PDF files. Learn more and download Adobe Reader directly from Adobe's website, www.adobe.com. Change your email address at any time by contacting the Fund Office at benefitservices@carpenterfunds.com, (510) 633-0333, or Toll-Free (888) 547-2054. The change must be in writing, with your signature.

Some example documents that may be sent electronically include: Summary Plan Descriptions, Notice of Plan changes, Explanation of Benefits, Benefit and Claim Department letters, Prohibited Employment Committee letters, and Fund Trustee memos.

Your consent to electronic delivery of Plan documents is valid unless and until you withdraw your consent. You can withdraw your consent and reset your preference to mail at any time by contacting the Fund Office at benefitservices@carpenterfunds.com, (510) 633-0333, or Toll-Free (888) 547-2054. The change must be in writing, with your signature. While e-delivery may significantly reduce the amount of mail we send you, certain documents and service-related correspondence will continue to be sent via U.S. Mail. Additionally, you may request a paper copy of any documents received electronically. Unless otherwise instructed, your email address will be shared with the Carpenters Union, Apprenticeship Training Committee and the Carpenters Trust Funds.

Signature Date

Once you have completed this document, return it to:

Carpenter Funds Administrative Office of Northern California, Inc.

PO Box 2380, Oakland, California 94614

benefitservices@carpenterfunds.com

Fax: (510) 633-0215