CARPENTERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA

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ELECTION TO TERMINATE/DELAY RETIREE HEALTH COVERAGE (KAISER PLAN INCLUDING KAISER SENIOR ADVANTAGE)

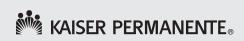
- Complete only if you want to cancel health coverage for you and/or your dependent(s).
- > If you are Medicare eligible you must ALSO complete the enclosed Kaiser Disenrollment Form.

	•	coverage for yourse ncel a dependent ch	•	•		•	
	-	•	-				or:
	☐ Myself a	nd my dependents,	if any.				
	•	endent(s) only. w name(s) of depen	dents(s) who	ose coverage s	hould be cance	eled.	
	1 ^{s1}	Dependent's Name				_	
	2 ⁿ	^d Dependent's Name				_	
Carpe > Pleas	nters Retiree I am cancelinglan. I am not yet I I have acquir e indicate the I (or my depen	understand that I Health Plan at any ng this coverage be Medicare eligible an ed a new dependen ne reason you are dent) am covered by a Carpenters Retiree	further date cause I am d have provide through made terminating another employed.	e after I cance covered under ded proof of Marriage, birth, acong/delaying reports of the covered grown sponsored grown sponso	I this coverage another employed another employed another employed another employed another enrollm doption or legal etiree health plant another the enrollment of the enrollm	e, <u>unless</u> oyer sponsored nent within 60 c I guardianship. coverage:	d group health days. nat I will have 31
Employ	er Name			Employee I	Name		
Insurar	nce Carrier or H	ealth Plan Name		Plan Num	ber		
that co	m other than Me verage ends. I ເ	ndent) am covered by edicare. I understand t understand that if I (or nid or CHIP, I have 60	hat I will have my depender	e 60 days to enro nt) become eligib	II in the Carpentolle to participate	ers Retiree Heal in a premium as	lth Plan after
Retiree	Signature			Date			

UBC#, ID, or Social Security Number

Retiree's Name (Print)

Kaiser Permanente Senior Advantage (HMO) or Kaiser Permanente Senior Advantage Medicare Medi-Cal (HMO SNP) Plan DISENROLLMENT FORM



KAISER PERMANENTE MEDICAL/

Northern California or Southern California Region

FIRST NAME

MI

Each individual disenrolling will need to complete his/her own form. If you have any questions, please call Kaiser Permanente at **1-800-443-0815** (TTY **711** for the hearing/speech impaired), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you <u>must</u> continue to get all medical care from Kaiser Permanente, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment <u>before</u> you seek medical services outside of Kaiser Permanente's network. We will notify you of your effective date of disenrollment in writing after we get this form from you.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

LAST NAME

HEALTH RECORD #						
	MAILING AD	DDRESS				
MEDICARE #	CITY	STATE	ZIP			
BIRTH DATE	SEX:	HOME PHONE NUMBER				
Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Disenrollment Period from January 1 through February 14 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.						
PLEASE SELECT A DISENROL By checking any of the followin eligible for an Election Period.		L OW Tying that, to the best of your knowle	dge, you are			
 ☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums. ☐ I get extra help paying for Medicare prescription drug coverage. ☐ I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date)						

Please carefully read and complete the following information before signing and dating this disenrollment form.

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente Senior Advantage Plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

If you have selected to have Medicare prescription drug coverage from Kaiser Permanente, by disenrolling from Kaiser Permanente Senior Advantage you are also disenrolling from Medicare prescription drug coverage. You generally may only change to a new Medicare drug plan during certain times of the year. If you do not have Medicare drug coverage, or other coverage that is at least as good as Medicare drug coverage, you may have to pay a penalty in addition to your plan premium for Medicare drug coverage in the future. For information about drug plans available in your area you can call **1-800-MEDICARE** (1-800-633-4227) 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior Advantage for Federal employees.

Your signature*	Date

If you are the authorized representative, you must provide the following information:

Name	
Address	
Phone	
Relationship to enrollee	

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This information is available in a different format by calling the number listed in the first paragraph.

Return the top, signed white copy to:

Kaiser Permanente – Medicare Unit P.O. Box 232400 San Diego, CA 92193

If required, send the middle copy to your employer group or union/trust fund. Keep the bottom copy for your records.

^{*}Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: (1) this person is authorized under State law to complete this disenrollment; and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.