Professional Musicians Local 47 Health and Welfare

2019 Level B - Enrollment Form

STEP 1 EMPLOYEE INFORMATION ■ **NEW ADDRESS**

Last Name	First Name	Middle Int.	Birth Date	**LAST 4 Digits** of Social Security No.

Address	Home Phone	Business Phone

City	State	Zip Code

STEP 2 FAMILY ENROLLMENT OPTION

❑ Member ❑ Member + One ❑ Member + Family

STEP 3 BENEFIT SELECTION

SELECT MEDICAL PLAN – PLANS INCLUDE LANDMARK CHIROPRACTIC/ACUPUNCTURE

❑ Blue Shield PPO HSA Qualified Plan Deductible $1,350 / $2,700-90%/70%	❑ Blue Shield Access+HMO $25 Office Visit co-pay $100+25%Hospital co-pay	❑ Blue Shield –Trio HMO Narrow Network $20-25% / $1,500 Deductible
❑ Kaiser Traditional HMO $30 co-pay / $500 Hospital	❑ Kaiser Deductible HMO $20 co-pay / $1,500 Deductible	❑ Kaiser High Deductible HSA Qualified HMO $30 co-pay / $2,700 Deductible

STEP 4 BLUE SHIELD PROVIDER INFORMATION REQUIRED *SKIP IF ENROLLING IN KAISER*

Blue Shield- Primary Care Physician Name (PCP)	Primary Care Physician ID (PCP ID#)	Existing Patient ❑Yes ❑No

STEP 5 SELECT DENTAL & VISION PLAN *SKIP IF CHOOSING MEDICAL ONLY*

❑ Delta Dental (PPO) & MES Vision ❑ DeltaCare USA (HMO) & MES Vision

STEP 6 DELTACARE USA - PROVIDER INFORMATION

Dental Provider #

STEP 7 LIST DEPENDENT(S) TO BE COVERED

Last Name	First Name	Date of Birth	SSN	M or F	Primary Care Physician Name	Primary Care Physician ID (PCP ID#)
Spouse						
Dependent						
Dependent						
Dependent						

STEP 8 PLEASE READ CAREFULLY AND SIGN BELOW

I APPLY FOR BENEFITS FOR THE PERSONS LISTED AND I AGREE THAT MY FAMILY AND I SHALL ABIDE BY THE PROVISIONS OF SERVICE AGREEMENTS UNDER WHICH WE ARE ENROLLED. I understand that misrepresentations in answering questions on this application or non-payment of premium may result in cancellation of membership. All benefits and exclusions are set forth in the Service Agreement of the Health or dental Plan. I understand that it is my responsibility to report to the Administrator any change in eligibility of my dependents. I agree to abide by the provisions as outlined.
AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION: I authorize any "provider of care", insurer or health plan to disclose to the Health/Dental Plan (s) or their representatives all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse or mental or emotional conditions, regarding me, my spouse, or my children. This medical review information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This Authorization will remain valid for the term of coverage of the health/dental service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization. I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, 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 the Health Plan, 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 in the Health Plan's coverage document, which is available for my review.

SIGNATURE OF APPLICANT X _____ DATE _____

TO BE COMPLETED BY ADMINISTRATOR

Amount Paid	Check #	Unit No.	Effective Date Of Coverage
$		3000-	