ENROLLMENT FORM

BAY AREA AUTOMOTIVE GROUP WELFARE FUND

4160 DUBLIN BLVD., #100 • DUBLIN, CALIFORNIA 94568

TYPEWRITTEN OR PRINTED INK ONLY

PLEASE READ CAREFULLY: This enrollment form is to be completed and signed by the employee only and all requires information must be provided. Applications containing illegible, missing or incomplete information will not be accepted. All information appearing on your application for coverage is subject to verification and periodic audit. Applications containing false, inaccurate or misleading information (including omissions) will be grounds for denial of some or all benefits available under the Trust. In the even that benefits are granted based on information that is later determined to be inaccurate, false or misleading, Bay Area Automotive Group Welfare Fund reserves the right to review certificates of marriage and any other documentation of dependent relationships as well as the right to recover any and all funds paid as the result of fraudulent information, as authorized by law.

I have read and understand the above: _____ _____

EMPLOYEE'S SIGNATURE DATE

1. SOCIAL SECURITY NUMBER	2. NAME (Last, First, MI)	3. DATE OF BIRTH _____ month/day/year	4. SEX ☐ MALE ☐ FEMALE
5. ADDRESS		6. HOME PHONE ( )	
7. CITY STATE ZIP		7. CELL PHONE ( )	

9. EMPLOYER	10. RECEIVE TEXT MSGS?* ☐ YES ☐ NO	11. E-MAIL ADDRESS

* Mark "NO" if you do NOT want to receive important benefit notifications via text message.

DEPENDENT INFORMATION

11. Please complete the following dependent enrollment information. If married, you must provide a copy of your marriage certificate. If in a domestic partnership, please indicate by writing "Domestic Partner" in the relationship box. If you elect to cover your Domestic Partner you will be required to make monthly payments for the employee portion of payroll taxes as well as pay taxes on the value of your domestic partner benefit. You must provide a birth certificate for each eligible dependent child. If your child is adopted or if you are a court-appointed guardian, please submit adoption papers or court papers establishing your legal guardianship in lieu of birth certificate. Please indicate if you are enrolling a stepchild by writing "stepson" or "stepdaughter" in the relationship box.

FULL FIRST NAME	M.I.	LAST NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER (MUST BE PROVIDED)

12. If you have more than 5 dependents, check here ☐ and obtain an additional enrollment form, mark it "FORM 2" at the top and list your additional dependents under Item 11.

13. Does anyone listed on this form have health insurance through another source? ☐ YES ☐ NO

If Yes, name of other coverage and persons covered: _____

BENEFICIARY INFORMATION

14. Death Benefits, if applicable, are paid to:

Give person(s) full Legal Name, Address, Relationship, Address, Social Security Number and Date of Birth. If a minor, also list the Guardian. If your plan has a death benefit, any applicable benefit will be shared equally amongst the beneficiaries listed below unless you designate a percentage (%) amount in the box next to the Date of Birth.

BENEFICIARY FULL NAME	ADDRESS	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	%

OVER

Each participant must notify the Administrative Office promptly when any change occurs in family status due to marriage, establishing a domestic partnership, birth of a child, death, dissolution of marriage (divorce) or domestic partnership, or change of beneficiary. A new Enrollment Form must be completed and mailed to the Administrative Office when a change occurs.

15. I certify that all statements and information provided by me represents a complete and truthful disclosure and that each individual named on this form is either my lawfully wedded spouse, my certified domestic partner or my true and legal dependent child(ren).

X_____ _____

EMPLOYEE'S SIGNATURE DATE

PLAN ELECTIONS

MEDICAL SELECTION: (Please check only one)

☐ KAISER **HMO** PLAN

☐ SELF-FUNDED **PPO** PLAN (ANTHEM BLUE CROSS NETWORK)

Please make your medical election carefully. Your choices are binding for 12 months. You will not be allowed to make another change until you are eligible for your next rolling open enrollment, unless you change employers.

IF YOU ELECT THE KAISER HMO MEDICAL PLAN, YOU MUST SIGN THE KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT BELOW. IF YOU FAIL TO DO SO, YOU WILL NOT BE ENROLLED IN THE KAISER HMO MEDICAL PLAN.

Kaiser Foundation Health Plan, Inc., 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.

_____ _____

Signature Required for all Kaiser Permanente Plans **Date**

**Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*

For Administrator Use Only:

Group Name	Group Number	Effective Date

AFTER YOU HAVE COMPLETED BOTH SIDES OF THIS FORM, RETURN IT TO:

Bay Area Automotive Group Welfare Fund
Attn: Participant Services
4160 Dublin Blvd., #100
Dublin, CA 94568
baagsupport@hsba.com

Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-267-3232.