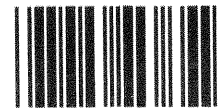




**NORTHERN CALIFORNIA CARPENTERS FUNDS ENROLLMENT FORM**  
 P.O. BOX 2280, OAKLAND, CALIFORNIA 94621-0180 • TELEPHONE (510) 633-0333 (888) 547-2054



TYPEWRITTEN OR BLACK INK ONLY

NEW EMPLOYEE

UPDATE RECORD

1. SOCIAL SECURITY NO.	2. UBC #	3. NAME (LAST) (FIRST) (MIDDLE)	4. DATE OF BIRTH MO DAY YR
5. ADDRESS (NUMBER) STREET - LINE 1 <input type="checkbox"/> Check if new address		6. RETIRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	7. SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
ADDRESS - LINE 2		8. HOME PHONE ( ) (AREA CODE)	
CITY	STATE	ZIP	COUNTRY
9. CURRENT OR MOST RECENT EMPLOYER		LOCAL UNION NUMBER	JOIN DATE
OCCUPATION:		SKILL CLASS	
10. ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED PARTICIPANT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE DECEASED PARTICIPANT'S SOCIAL SECURITY NUMBER: _____			

**11. HEALTH PLAN SELECTION**

**ACTIVE PARTICIPANT:** PLEASE CHECK ONLY ONE

- INDEMNITY MEDICAL PLAN
- KAISER PERMANENTE
- INTERNATIONAL BENEFIT OPTION (See Item #11 on the back of this form)

**RETIRED PARTICIPANT:** PLEASE CHECK ONLY ONE

- INDEMNITY MEDICAL PLAN
- KAISER PERMANENTE
- HEALTH NET (Not available to Active Participants)

**12. MARRIAGE & DEPENDENT INFORMATION**

CHECK ONE  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED

FORMER SPOUSE'S NAME \_\_\_\_\_

MO. DAY YR. MO. DAY YR. MO. DAY YR. MO. DAY YR.

**WHEN ADDING OR DROPPING A DEPENDENT, Certified Documentation is Required, See Back Page Item 12.**  
**DEPENDENTS: LIST NAMES OF ELIGIBLE DEPENDENTS, SEE INSTRUCTIONS ON BACK PAGE.**

FULL FIRST NAME	MI	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	SOCIAL SECURITY #	ADD DEPENDENT	MEDICARE ELIGIBLE ?	ATTACHED PROOF OF RELATIONSHIP ?	RELATIONSHIP
A.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER
B.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SON DAUGHTER STEPSON STEPDAUGHTER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
C.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SON DAUGHTER STEPSON STEPDAUGHTER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
D.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SON DAUGHTER STEPSON STEPDAUGHTER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
E.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SON DAUGHTER STEPSON STEPDAUGHTER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
F.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SON DAUGHTER STEPSON STEPDAUGHTER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**13. BENEFICIARY INFORMATION**

DEATH BENEFITS AND/OR VACATION ACCRUALS ARE TO BE PAID TO: GIVE PERSON(S) FULL LEGAL NAME, RELATIONSHIP, ADDRESS AND SOCIAL SECURITY NUMBER, IF A MINOR, ALSO LIST GUARDIAN. THE PERSON(S) NAMED WILL BE CONSIDERED YOUR BENEFICIARY UNDER ALL CARPENTER PLANS. IF YOU WOULD LIKE TO DESIGNATE MULTIPLE BENEFICIARIES OR DIFFERENT BENEFICIARIES FOR DIFFERENT FUNDS, PLEASE PROVIDE THAT INFORMATION ON A BENEFICIARY DESIGNATION FORM, WHICH IS AVAILABLE AT THE FUND OFFICE.

NAME(S) RELATIONSHIP ADDRESS (STREET/CITY/STATE) BIRTHDAY SOCIAL SECURITY NO.

IF BENEFICIARY IS A MINOR, PLEASE PROVIDE NAME AND COMPLETE ADDRESS OF GUARDIAN

NAME: ADDRESS:

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 THE SERVICE AGREEMENT PROVIDES 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 OF A PATIENT, HAS CAUSED ANY HARM, MUST BE SUBMITTED TO BINDING ARBITRATION INSTEAD OF A COURT TRIAL. (HEALTH NET DOES NOT REQUIRE MEDICAL MALPRACTICE CLAIMS TO BE SUBMITTED TO AN ARBITRATOR.)

**KAISER PERMANENTE ARBITRATION AGREEMENT:** I UNDERSTAND THAT (EXCEPT FOR SMALL CLAIMS COURT CASES, CLAIMS SUBJECT TO A MEDICARE APPEALS PROCEDURE, AND, IF MY GROUP MUST COMPLY WITH ERISA, CERTAIN BENEFIT-RELATED DISPUTES) ANY DISPUTES BETWEEN MYSELF, MY HEIRS OR OTHER ASSOCIATED PARTIES ON THE ONE HAND AND HEALTH PLAN, ITS HEALTH CARE PROVIDERS, OR OTHER ASSOCIATED PARTIES ON THE OTHER HAND, FOR ALLEGED VIOLATION OF ANY DUTY ARISING OUT OF OR RELATED TO MEMBERSHIP IN HEALTH PLAN, INCLUDING ANY CLAIM FOR MEDICAL OR HOSPITAL MALPRACTICE, 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. 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.

14. \_\_\_\_\_  
 (SIGNATURE) (DATE)



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

Dear Participant:

You should carefully complete this enrollment form and fill in the required information as neatly and clearly as possible. This information is an important part of your official record with the Fund. Most of the items clearly indicate the information required; however, instructions are listed below for those items that might need further explanation.

**Item 1** Fill in your Social Security Number as it appears on your Social Security card.

**Item 4** Please fill in the month, day, and year of your birth. The year alone is not enough.

**Item 11** **Active Participants:** You have the choice of one of either: the Indemnity Medical Plan, Kaiser Permanente, or the International Benefit Option. Only participants whose dependents reside outside the United States should enroll in the International Benefit Option, which provides Indemnity Coverage for the Participant, and provides for a reimbursement of premiums paid to a foreign government to purchase health care. If you elect the International Benefit Option your dependents will NOT be eligible for benefits under this Plan. **If you elect the Indemnity Medical Plan please note: "PHANTOM COB RULES" limit spousal coverage for working spouses who do not elect health and welfare from his/her own employer if coverage is available.**

**Retired Participants:** You have the choice of one of either: the Indemnity Medical Plan, Kaiser Permanente, or Heath Net.

**Item 12** **WHEN ADDING DEPENDENTS**

The Fund has the right to request proof of marriage, of divorce, or of birth to verify the information given and to determine the eligibility of a dependent for enrollment.

Eligible dependents are:

- I. **Your lawful spouse or qualified domestic partner.** In the event of a final dissolution of your marriage (divorce), your spouse is no longer eligible for coverage and you should immediately complete and mail a new enrollment form to the Fund Office to delete your spouse as your dependent. If you fail to do so, you may be held responsible for repayment of any benefits provided to which your former spouse is no longer entitled. **[CERTIFICATION REQUIRED: Certified Marriage Certificate or license, recorded final marriage dissolution document.]**
- II. **A Participant's unmarried children under age 19.** This includes stepchildren or children for whom the Participant has been appointed legal guardian, provided the child is younger than 19 years of age, lives with the Participant and is primarily dependent upon him for support. **[CERTIFICATION REQUIRED: Birth Certificate, Legal Guardianship papers.]**
- III. **Your unmarried children over 19 but under age 23,** provided they are financially dependent upon you and they are attending an educational or training institution as a full-time student. **[CERTIFICATION REQUIRED: Proof of full-time attendance at an accredited institution.]**
- IV. **An unmarried child of any age who is unable to earn a living because of mental or physical handicap** is also considered an eligible dependent, provided the child was both handicapped and eligible under the Fund when he attained limiting age, and is primarily dependent upon the Participant for support. Evidence of the child's dependence and incapacity must be filed with the Indemnity Medical Plan or the HMO of your choice and the Fund. **[CERTIFICATION REQUIRED: Physician Statement]**

**Item 13** If you are not now and have never been married, your beneficiary may be any person or persons you name. If you are married at the time of your death, death benefits under the Pension Plan and Annuity Plan are payable only to your surviving spouse, unless he or she has previously authorized an alternate beneficiary. If you were once married but have been divorced, you may be required to obtain the consent of your former spouse to the designation of anyone else as a beneficiary of such benefits. You may request a change of beneficiary at any time by submitting a new Enrollment Form or Beneficiary Designation Form and any necessary consents. If you fail to name a beneficiary, the probate of your estate may be necessary. The person or persons named will be considered your beneficiary under all of the Carpenter Plans unless you specify otherwise.

**Item 14** **Be sure you sign and date this form and return it to the Fund Office. Also, be certain you have listed all dates of birth correctly, and all dependents.**

*After you have completed the reverse side of this form, return to:*

**CARPENTER FUNDS ADMINISTRATIVE OFFICE OF NORTHERN CALIFORNIA, INC.  
P.O. Box 2280, Oakland, California 94621-0180**