

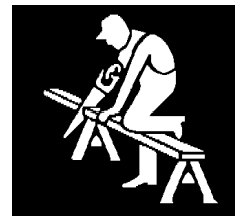
**CARPENTER FUNDS ADMINISTRATIVE OFFICE  
OF NORTHERN CALIFORNIA**

265 Hegenberger Road, Suite 100, Oakland, CA 94621

PO Box 2280, Oakland, CA 94614

Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

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**ELECCIÓN PARA TERMINAR/DEMORAR LA COBERTURA MÉDICA PARA JUBILADOS  
(PLAN MÉDICO KAISER INCLUYENDO KAISER SENIOR ADVANTAGE)**

- Complete este formulario solo si desea cancelar la cobertura médica para usted y/o para su(s) dependiente(s)
- Si usted cancela su propia cobertura se cancelará la cobertura de su(s) dependiente(s)
- Ya que se cancele la cobertura de su(s) hijo(s) dependiente(s) no sera(n) elegible para reinscribirse en el plan medico

A partir de \_\_\_\_\_, eligo cancelar la cobertura médica para jubilados:

Mia y de mi(s) dependiente(s), si lo(s) tengo.

Solamente de mi(s) dependiente(s).

Escriba a continuación el nombre del(los) dependiente(s) cuya cobertura se debe cancelar.

Nombre del 1<sup>er</sup> dependiente: \_\_\_\_\_

Nombre del 2<sup>o</sup> dependiente: \_\_\_\_\_

**FAVOR DE LEER: Entiendo que no se permitirá que yo (y/o mi(s) dependiente(s)) me reinscriba en el Plan Médico para Jubilados de Carpenters en ninguna fecha futura después de que cancele esta cobertura, a menos que**

- esté cancelando esta cobertura debido a que tengo cobertura bajo otro plan medico.
- no soy elegible para Medicare y he proporcionado un comprobante de inscripción en Medicare dentro de 60 días.
- he adquirido un nuevo dependiente mediante matrimonio, nacimiento, adopción o tutela legal y lo(s) inscribiré y proveeré la documentación requerida dentro 60 días de la fecha en que adquieré el/los nuevo(s) dependiente(s).

**Por favor indique la razón por la cual está cancelando/demorando la cobertura médica para jubilados:**

- Yo (o mi(s) dependiente(s)) tengo cobertura bajo otro plan médico. Entiendo que tendré 31 días para reinscribirme en el Plan Médico para Jubilados de Carpenters después de que termine la otra cobertura.

Nombre del empleador

Nombre del empleado

Nombre de la compañía aseguradora o del plan medico

Número del plan

- Yo (o mi(s) dependiente(s)) tengo cobertura de Medicaid, un Programa estatal de Seguro Médico para Niños (Children's Health Insurance Program, CHIP), o de otro programa público que no sea Medicare. Entiendo que tendré 60 días para reinscribirme en el Plan Médico para Jubilados de Carpenters.

Nombre del jubilado (en letra de molde)

Nº UBC, de ID o de Seguro Social

Firma del jubilado

Fecha



**Kaiser Permanente Senior Advantage (HMO) or  
Kaiser Permanente Senior Advantage Medicare Medi-Cal (HMO SNP) Plan  
DISENROLLMENT FORM  
Northern California or Southern California Region**

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 must 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 before 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			
KAISER PERMANENTE MEDICAL/ HEALTH RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	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 DISENROLLMENT REASON BELOW**

By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

<input type="checkbox"/> I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
<input type="checkbox"/> I get extra help paying for Medicare prescription drug coverage.
<input type="checkbox"/> I no longer qualify for extra help paying for my Medicare prescription drugs. I stopped receiving extra help on (insert date) _____.
<input type="checkbox"/> I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
<input type="checkbox"/> I am joining a PACE program on (insert date) _____.
<input type="checkbox"/> I am joining employer or union coverage on (insert date) _____. I am requesting a disenrollment date of (insert date) _____ with the understanding that this must be approved by CMS.
<input type="checkbox"/> I have moved out of the Kaiser Permanente service area on (insert date) _____. I am requesting a disenrollment date of _____ with the understanding that this must be approved by CMS.
<input type="checkbox"/> I have joined another plan with creditable prescription drug coverage (coverage as good as Medicare's) on (insert date) _____.
<input type="checkbox"/> My employer group coverage has ended or will transfer to a new health care plan on (insert date) _____. I am requesting a disenrollment date of _____ with the understanding that this must be approved by CMS.
<input type="checkbox"/> Other – Please explain _____.

**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** \_\_\_\_\_

\*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.

**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.



## **GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)**

The Carpenters Health and Welfare Trust Fund for California (“Fund” or “Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- b) Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Pauline Hann, Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Pauline Hann, Civil Rights Coordinator  
Carpenter Funds Administrative Office of Northern California, Inc.  
265 Hegenberger Rd., Suite 100  
Oakland, CA 94621  
Telephone number: (888) 547-2054, Fax: (510) 633-0215  
Email: [benefitservices@carpenterfunds.com](mailto:benefitservices@carpenterfunds.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pauline Hann, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW., Room 509F, HHH Building  
Washington, DC 20201  
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**ATTENTION: FREE LANGUAGE ASSISTANCE**

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (888) 547-2054. (TTY: 888-547-2054).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-547-2054 (TTY: 1-888-547-2054)。
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-547-2054 (ATS: 1-888-547-2054).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-547-2054 (TTY: 1-888-547-2054).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-547-2054 (TTY: 1-888-547-2054).
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-547-2054 (TTY: 1-888-547-2054).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-547-2054 (TTY: 1-888-547-2054).
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-547-2054 (TTY: 1-888-547-2054) تماس بگیرید.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-547-2054 (TTY: 1-888-547-2054) पर कॉल करें।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-547-2054 (TTY: 1-888-547-2054).
Navajo	Díí baa akó nínízin: Díí saad bee yáníłti'go <b>Diné Bizaad</b> , saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kóji' hódííłnih 1-888-547-2054 (TTY: 1-888-547-2054).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-547-2054-1 (رقم هاتف الصم والبكم: 1-888-547-2054).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-547-2054 (TTY: 1-888-547-2054) 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-547-2054 (TTY: 1-888-547-2054).
Lao	ໂປດ ຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາ ສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ, ໂດຍ ບໍ ຈ່າຍ ຄ່າ, ແມ່ນ ມີ ພ້ອມ ໃຫ້ ທ່ານ. ໂທ ໑ 1-888-547-2054 (TTY: 1-888-547-2054).