NORTHERN CALIFORNIA GENERAL TEAMSTERS SECURITY FUND

HEALTH PLAN ENROLLMENT FORM

P.O. BOX 1147, STOCKTON, CA 95201-1147
Phone: (800) 417-8923 | Fax: (209) 474-5402

DELTA HEALTH SYSTEMS

Employee's Last Name	First Name	MI	Social Security Number - -
Address – House # & Street Name or PO Box			Date of Birth (Mo/Day/Yr) / /
City, State, Zip Code			☐ Male ☐ Female ☐ Single ☐ Married
Daytime Phone Number	Home Phone Number	Employee's Email Address	
Employer Name	Date of Hire (Mo/Day/Yr) / /	Effective Date (Mo/Day/Yr) / /	
Life Insurance Beneficiary	Relationship		

HEALTH PLAN COVERAGE (please select one)

☐ PPO Medical / Rx / Dental / VSP / Life

☐ Kaiser Medical / Rx / Vision and Dental / Life
I understand I must work or reside within a Northern California Kaiser service area to elect Kaiser coverage and must also complete the Kaiser Subscriber Enrollment/Change form.

DENTAL PLAN COVERAGE (please select one)

☐ PPO DENTAL PLAN

☐ ANTHEM DENTAL DHMO. All dental care must be provided by one of the Anthem Dental DHMO Dental providers.

☐ NEWPORT DENTAL DHMO. All dental care must be provided by one of the Newport Dental DHMO Dental providers.

HEALTH PLAN ENROLLMENT FORM

PLEASE LIST DEPENDENTS TO BE COVERED. You must attach a county-recorded marriage and/or birth certificate for each newly enrolled dependent.					
Relationship	**Last Name, First Name, MI**	**Date of Birth (Mo/Day/Yr)** / **Social Security Number**		**If dependent has other health insurance, indicate ID# and carrier name**	**Name of Employer or College, if Applicable**
☐ Husband ☐ Wife ☐ Domestic Partner		**DOB:**	/ /	☐ **No**	
		SSN:	- -	☐ **Yes ID#** **Name of Carrier:**	
☐ Son ☐ Daughter ☐ Stepchild		**DOB:**	/ /	☐ **No**	
		SSN:	- -	☐ **Yes ID#** **Name of Carrier:**	
☐ Son ☐ Daughter ☐ Stepchild		**DOB:**	/ /	☐ **No**	
		SSN:	- -	☐ **Yes ID#** **Name of Carrier:**	
☐ Son ☐ Daughter ☐ Stepchild		**DOB:**	/ /	☐ **No**	
		SSN:	- -	☐ **Yes ID#** **Name of Carrier:**	
☐ Son ☐ Daughter ☐ Stepchild		**DOB:**	/ /	☐ **No**	
		SSN:	- -	☐ **Yes ID#** **Name of Carrier:**	

EMPLOYEE SIGNATURE AND CONSENT

I understand that I cannot change/revoke this election during the plan year unless I experience a change in family status (i.e. marriage/divorce, birth/adoption of a child, death of a family member, involuntary termination of a spouse's employment), or move out of the Northern California Kaiser or Anthem Dental DHMO/Newport Dental DHMO service area. I understand that this election will continue in effect until modified by a subsequent election.

I understand that The Northern California General Teamsters Security Fund ["Health Plan"] may use my health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. I understand that the Health Plan has established a policy to guard against unnecessary disclosure of my health information.

I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative, professional, medical, or legal services in connection with me or my covered dependents to disclose any information necessary for investigation, evaluation, or payment of a claim.

I certify that all information contained herein is true and correct.

_______________________________ _______________________

Employee Signature Date