* IMPORTANT INFORMATION *

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 which might need explaining.

- Fill in your Social Security Number as it appears on your Social Security card.

- Please fill in the month, day and year when asked to provide dates of birth. The year alone is not enough.

- 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:

Your lawful spouse. In the event of a final dissolution of your marriage (divorce), the 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, recorded final marriage dissolution document.)

Your domestic partner. Domestic Partners are defined as same sex and opposite sex couples registered with any state or local government agency authorized to perform such registrations.

(CERTIFICATION REQUIRED: Certificate of Domestic Partnership or equivalent form.)

ACTIVE PARTICIPANTS: Your children under age 26 including your natural children, stepchildren (including children of your domestic partner) who live in your household, legally adopted children, children for whom you have been appointed Legal Guardianship, foster children, children designated as your Dependent in a valid and approved QMCSO.

(CERTIFICATION REQUIRED: Birth Certificate, Legal Guardianship papers, QMCSO.)

RETIREE PARTICIPANTS: Your unmarried children under age 19 whose relationship is defined above and provided they primarily depend on you for financial support. Unmarried children age 19 to 24 provided they are attending an accredited school or college as a full-time student and primarily depend on you for financial support.

(CERTIFICATION REQUIRED: Full-time student verification.)

An unmarried child of any age who is unable to earn a living because of a disability is also considered an eligible dependent, provided the child was both disabled and eligible under the Fund before reaching age 26 (Actives) or age 19 (Retirees) and provides proof of disability within 31 days of reaching the age limitation.

(CERTIFICATION REQUIRED: Physician Statement.)

If you have more eligible dependents than the allotted space, you should obtain an additional enrollment form and mark it with *"FORM 2"* at the top. On Form 2, complete only the Personal and Dependent Information section and list only your additional dependents.

Be sure to sign and date this form and return it to the Trust Fund Office at:

Bay Area Delivery Drivers Security Fund, 4160 Dublin Blvd., Suite 100, Dublin, CA 94568

BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD., SUITE 100 | DUBLIN, CA 94568
TEL: (925) 833-7300 | TOLL-FREE: (800) 654-1824 | FAX: (925) 833-7301

ACTIVE APPLICATION

ENROLLMENT FORM

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

MAILING ADDRESS (STREET OR P.O. BOX)	SEX (M/F)	DATE OF BIRTH

CITY	STATE	ZIP	MAIN NUMBER	MOBILE NUMBER
			( ) -	( ) -

EMPLOYER	LOCAL UNION

MARITAL STATUS	DATE OF MARRIAGE / DIVORCE DOMESTIC PARTNER REGISTRATION	E-MAIL ADDRESS
☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED		**WOULD YOU LIKE TO BE CONTACTED OF ANY CHANGES IN YOUR BENEFITS VIA TEXT OR EMAIL?** ☐ YES ☐ NO

CHOICE OF PLANS

MEDICAL SELECTION – CHOOSE ONE:

- ☐ **PPO PLAN:** INDEMNITY (ANTHEM BLUE CROSS)
- ☐ **HMO PLAN:** KAISER PERMANENTE

DENTAL OPT-OUT

☐ **EXCLUDE DENTAL COVERAGE**
***CHECK HERE ONLY IF YOU WANT TO OPT-OUT OF DENTAL COVERAGE**

DEPENDENT INFORMATION

Please complete the following dependent enrollment information

PLEASE SEE PAGE ONE FOR EXPLANATION OF "WHO IS ELIGIBLE".

Your dependents will not be enrolled until this information is provided:

***SPOUSE – Copy of marriage certificate**

****CHILD – SON, DAUGHTER, STEPSON, STEPDAUGHTER, ETC. – Copy of birth certificate, adoption papers or court papers establishing your legal guardianship in lieu of birth certificate for each child**

*****DOMESTIC PARTNER – Attach a state of California declaration of domestic partnership or other local registry document.**

LAST NAME	FIRST NAME	M.I.	SEX	D.O.B	SOCIAL SECURITY NO.	RELATION*	DISABLED
			M / F			☐ SPOUSE ☐ DOMESTIC PARTNER**	Y / N
			M / F			☐ CHILD ☐ STEPCHILD ☐ OTHER*	Y / N
			M / F			☐ CHILD ☐ STEPCHILD ☐ OTHER*	Y / N
			M / F			☐ CHILD ☐ STEPCHILD ☐ OTHER*	Y / N

(SEE REVERSE SIDE)

Does anyone listed on this form have health insurance through another source? ☐ Yes ☐ No

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

_____

***Please attach copy of insurance card. A dual coverage questionnaire may be sent for additional information.

COMPLETE THE SECTION BELOW AND ENCLOSE A COPY OF THE MEDICARE CARD IF YOU OR A DEPENDENT(S) ARE ENROLLED IN MEDICARE

PLEASE LIST THE INDIVIDUAL(S) RECEIVING MEDICARE	RECEIVING PART A? ☐ YES ☐ NO	RECEIVING PART B? ☐ YES ☐ NO
NAME:_____	EFFECTIVE DATE A:	EFFECTIVE DATE B:
NAME:_____	_____/_____/_____	_____/_____/_____

IS ANYONE LISTED RECEIVING KIDNEY DIALYSIS OR A TRANSPLANT

PLEASE LIST THE INDIVIDUAL(S) RECEIVING DIALYSIS OR TRANSPLANT	RECEIVED KIDNEY TRANSPLANT	RECEIVING DIALYSIS
NAME:_____	☐ Yes ☐ No	☐ Yes ☐ No
NAME:_____	DATE OF TRANSPLANT:	DATE OF FIRST TREATMENT:
	_____/_____/____	_____/_____/____

BENEFICIARY INFORMATION

Death Benefits are to be paid to:

NAME: _____ RELATIONSHIP: _____
ALLOCATION: _____ %

NAME: _____ RELATIONSHIP: _____
ALLOCATION: _____ %

Give person(s) full Legal Name and Relationship. If a minor, also list Guardian. The person(s) named will be considered your beneficiary unless you specify otherwise.

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

- **I understand that all questions must be answered before Bay Area Delivery Drivers Security Fund can consider this enrollment request.**
- **I have read and understand the requirements, terms, conditions, limitations, provisions, and other information discussed in the enrollment materials.**
- **For the purposes of processing claims for benefits, on behalf of myself and enrolling family members, I AUTHORIZE the release and exchange of full information regarding school enrollment, medical history, consultation, or treatment, including copies of all records between and among all doctors, dentists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs or supplies, and any insurance carrier, service plan, union, trust fund, provider network, school, or employer, to the extent permitted by law.**
- **I declare that the statements contained in this enrollment form are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted.**
- **I understand that it is illegal, and is a felony in some states, for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an enrollment request containing any false, incomplete, or misleading information. In some states, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits.**

SIGNATURE: _____ **DATE**: _____