BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD, SUITE# 100 • DUBLIN, CA 94568
TEL: (800) 654-1824 • FAX (925) 833-7301
Email: BADDInfo@HSBA.com

Greetings Prospective Retiree,

Enclosed with this letter you will find information on retiree eligibility requirements, enrollment procedures and a Retiree Enrollment application for the Retiree Plan 11A & 11B.

When you make the decision to retire, be sure to contact the Human Resources Department at your employer for procedures to start the retirement process.

Before taking this application to the Local, be sure to call your Union Local office and verify their "in person" procedure.

You must take the following items to be signed on the back by the Secretary Treasurer of your Union Local:

1. **The Retiree application** completed by you and to be signed by an officer of your Union Local.
2. **Copy of one of the following:**
   a) **Pension Award Letter** from Western Conference of Teamsters or another Plan recognized for this purpose by the Board of Trustees
   b) **Social Security Award Notice** from the Social Security Administration for; Age Retirement or Disability

If you are **under age 65** and **not eligible** for Medicare, you have a monthly copay (staggered rate per age group). You may mail your first month's copay to: Bay Area Delivery Drivers Security Fund; PO Box 7685; Fremont, CA 94537-7685. A return envelope is enclosed.

Please read and complete the Retiree Enrollment application(s). Any missing information or documentation may delay the approval of your enrollment into the Retiree Plan.

Note: Medicare-eligible participants (and spouse) must also complete a Kaiser Permanente Senior Advantage enrollment form if you want to be enrolled in Kaiser even if you are currently enrolled in Kaiser.

Submit your completed documentation (including Kaiser applications) to the Bay Area Delivery Drivers Security Fund: 4160 Dublin Blvd Ste 400, Dublin, CA 94568-7756

Sincerely,
Participant Services Department

eff. 06/2025

READ CAREFULLY AND IN ITS ENTIRETY

Eligibility Rules

To be eligible for the Retiree plan(s), you must *satisfy all* the following rules:

First, you are eligible to participate in the Retiree plan if you are receiving:

- A pension from the Western Conference of Teamsters Pension Fund (or another Plan recognized for this purpose by the Board of Trustees), ***or***
- Social Security old age benefits, ***or***
- A pension from a plan sponsored by an employer that has participated in the Fund for at least ten consecutive years and has a current collective bargaining agreement and approved subscription agreement with a participating local union, ***or***
- Federal Social Security disability benefits for which you qualified while working in employment covered by the Fund as an active employee; **and**

Second, while an active employee you must have been eligible for benefits under a Bay Area Delivery Drivers Security Fund plan for active employees for at least **120** months, including at least **48** out of the last 60 months immediately preceding the effective date of your pension or disability; **and**

Third, you make the required monthly copayment, which is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated; **and**

Fourth, the Employer from which you retired remains a contributing employer in one or more of the Fund's Plans for active employees:
IF YOUR FORMER EMPLOYER LEAVES THE FUND, ITS RETIREES LOSE ELIGIBILITY IN THE RETIREE PLAN EFFECTIVE AT THE END OF THE MONTH IN WHICH THE EMPLOYER STOPS CONTRIBUTING TO THE FUND.

Why does a retiree lose eligibility in the Retiree Plan if his former Employer leaves the Trust Fund?

The Retiree Plan is primarily funded through employer contributions for active employees. Note, however, that if your former Employer files for bankruptcy and/or goes out of business, your retiree coverage will continue.

Enrollment for Newly Eligible Retirees

You will not be automatically enrolled in the Retiree Plan.

You must submit an enrollment application (even if you have been covered without interruption under the Active Employee Plan prior to your retirement).

To enroll in the Retiree plan, you must provide the following documentation:

1. **Retiree application** completed by you and signed by an officer of your Union Local.
2. **A Copy of either**
    a) **Pension Award Letter** from Western Conference of Teamsters or another Plan recognized for this purpose by the Board of Trustees
    b) **Social Security Award Notice** from the Social Security Administration for; Age Retirement or Disability
3. **Kaiser Permanente Senior Advantage enrollment form** ***(if applicable)***

Participants who are not yet eligible for Medicare Part B on the date of retirement will be enrolled in Plan 11A.

Note: Upon turning age 65 you must sign up with Medicare for Part B coverage. If you do not your benefits will be affected.

Participants who are or will become eligible for Medicare Part B on the date of retirement will be enrolled in Plan 11B.

Dependents who were eligible under your active coverage will continue to be covered under your Retiree plan as long as they meet the Plan's definition of a Dependent (refer to the plan SPD).

Retirees and their Dependents are ineligible for:

- Dependent Life Insurance (there is a reduced Life Benefit for the Retiree)
- AD & D and survivor income benefit; and
- Short-Term Disability Income Coverage.

To Be Completed by Teamster Union Local Secretary-Treasurer:

Member of Union Local Number:_____

From: _____ **To:** _____

Pension or Social Security Award from:_____

(A Copy of the Award letter must be accompanied with this application)

Verified by: _____

(*Secretary-Treasurer)*

To be Completed by Administration Office/HSBA:

Period Of Eligibility From: _____ **To:** _____

Employed by: _____

From: _____ **To:** _____

Verified by: _____

(Health Services & Benefit Administrators)

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

RETIREE 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	RETIREMENT DATE

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

DEPENDENT INFORMATION

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

*Dependent children are eligible if they are unmarried, less than nineteen (19) years of age or full-time students to age twenty-four (24) or disabled, residing with you and wholly dependent upon you for financial support.

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

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

IMPORTANT: You MUST sign up for both Part A and Part B Medicare at the time you are eligible. If you fail to sign up for Part B Medicare, **Indemnity Plan benefits will be paid as if you had signed up for Part B.** As a result, your benefits will be substantially reduced. If you are a Kaiser member you will be enrolled in the Indemnity Plan with reduced benefits. ***This requirement also applies to your spouse or other dependents***

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:_____ NAME:_____	EFFECTIVE DATE A: _____/_____/_____	EFFECTIVE DATE B: _____/_____/_____

(SEE REVERSE SIDE)

IS ANYONE LISTED RECEIVING KIDNEY DIALYSIS OR A TRANSPLANT		
PLEASE LIST THE INDIVIDUAL(S) RECEIVING DIALYSIS OR TRANSPLANT NAME:_____ NAME:_____	RECEIVED KIDNEY TRANSPLANT ☐ Yes ☐ No DATE OF TRANSPLANT: _____/_____/____	RECEIVING DIALYSIS ☐ Yes ☐ No 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.

MONTHLY CO-PAYMENT: If you retire on or after 10/01/2024 the following monthly co-payment is required. Please check the applicable rate below based on the age of the retiree (not spouse).

☐ Under age 55: $500/month ☐ Age 55 through 59: $400/month

☐ Age 60 through 64: $200/month ☐ Age 65 and over (or Medicare eligible): **No co-payment due**

*****Payment is due on the first day of each calendar month. If you fail to make the payment within thirty days of the date it is due, your coverage will be terminated and cannot be reinstated.***

On what basis did you obtain your pension? ☐ AGE or ☐ DISABILITY

*If you checked ***Disability*** you must attach a copy of your Social Security Award letter that shows the beginning date of your disability. You will be eligible for Medicare at age 65, if NOT disabled OR 24 months after the date you are eligible to receive Social Security Disability Benefits due to disability.

MEDICAL SELECTION – CHOOSE ONE:	**Required Document Attached**
☐ **PPO PLAN: INDEMNITY (ANTHEM BLUE CROSS)** ☐ **HMO PLAN: KAISER PERMANENTE** ***If you chose Kaiser, complete the additional application included in the packet**	☐ **PENSION AWARD LETTER - (WTC OR RECOGNIZED PLAN)** ☐ **SOCIAL SECURITY AWARD NOTICE - (AGE/DISABILITY/SURVIVOR)** ☐ **COPY OF MEDICARE CARD(S) - (MEMBER/DEPENDENT(S))** **I AM PENDING COPY FROM: ☐ WTC ☐ SOCIAL SECURITY OFFICE** ***PLEASE NOTE YOUR APPLICATION CANNOT BE COMPLETED WITHOUT PROVIDING ONE**

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** _____

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4160 DUBLIN BLVD., SUITE 100 • DUBLIN, CA 94568-7756
TEL. (925) 833-7300 • TOLL FREE (800) 654-1824 • FAX (925) 833-7301

KAISER WITHDRAWAL FORM

I want to withdraw from KAISER HMO and change to the fee-for-service (Indemnity Plan) medical plan provided by the Bay Area Delivery Drivers Security Fund, I understand that my medical coverage with the Bay Area Delivery Drivers Security Fund will become effective the 1st day of the month after this form is **completed and returned to the Trust office.**

Last Name	**First Name**	**M.I**

Street Address

City	**State**	**ZIP Code**

Plan ID Number or Social Security Number	**Signature**	**Date Signed**

Send form to:
Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd, Suite 100
Dublin, CA 94568-7756

Or FAX to 925-833-7301

KAISER PERMANENTE®

Group Plan

Kaiser Permanente Senior Advantage (HMO)

Group Medicare Election Form

Filling out and returning the enrollment form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing the enrollment form, call Kaiser Permanente at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

   You can also FAX or EMAIL your completed form to:
   FAX: **1-855-355-5334**
   EMAIL: **KPMedicareEnrollments@kp.org**
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus**.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Employer Group Use Only
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information

Employer or Union Name: _____ Group #: _____

LAST Name: _____

FIRST Name: _____ Middle Initial: _____ Gender: ☐ Male ☐ Female

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number: _____

Permanent Residence Street Address (P.O. Box is not allowed): _____

City: _____

County: _____ State: _____ ZIP Code: _____

Home Phone Number: _____ Mobile Phone Number: _____ Birth Date: (mm/dd/yyyy) _____

Mailing Address (only if different from your Permanent Residence Address)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

2. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (mm/dd/yyyy):
   If no, name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse:
   Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution:
   Address of institution (number and street): Phone Number:

Last Name _____ First Name _____

6. Requested effective date (subject to CMS approval): _____

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What's your race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese ☐ Braille ☐ Large Print ☐ Audio CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

Please complete the information below

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name: _____

Employer Group/Union/Trust Fund ID #: _____ Subgroup: _____ Requested effective date (subject to CMS approval): _____

Last Name _____ First Name _____

Please Read and Sign Below

FOR CALIFORNIA ENROLLEES ONLY:

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: _____

Today's Date: _____

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however most employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Last Name _____ First Name _____

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Release of Information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature: _____

Today's Date: _____

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: _____ **Relationship to Enrollee:** _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____