SOUTHWEST CARPENTERS TRUSTS ENROLLMENT FORM

533 S. FREMONT AVENUE, LOS ANGELES, CA 90071
EMAIL TO: ENROLLMENT@CARPENTERSSW.ORG
FAX TO: (213) 739 - 9437

Directions: Complete this form upon Enrollment in the Plans administered by CSAC or use this form to update your record.

CHECK ONE	New Participant?		Updating Your Record?	

PARTICIPANT INFORMATION

Social Security Number	Date of Birth (MM/DD/YYYY)	Are you Retired? (Check One)	Yes	No
Last Name	First Name		MI	
Street Address	City	State	Zip Code	
Local Union #	Initiation Date	Sex (Check One)	M	F
Email Address	Phone #			

Check One				
Yes		No		I consent to receive electronic delivery of Plan documents by email or text message.

In the event the Administrative Office is unable to locate you to distribute benefits, please provide the name and contact information for a person who does not live with you that would help the Administrative Office locate you.

Name	Relation
Email Address	Phone Number

Electronic Delivery of Plan Correspondence

As a participant, you are entitled to important materials explaining how your various benefits work. You have the option to receive this information electronically by email. Electronic documents or a link to a document in PDF format may be emailed to the address you provided. The PDF version of the document is identical to the paper version you would otherwise receive in the mail.

You may also receive important alerts regarding your plan benefits via text messaging.

The delivery of documents to you by email may reduce the amount of mail you receive from the Administrative Office. However, certain documents and service-related correspondence may continue to be sent via U.S. Mail.

- Your consent to receive electronic delivery of Plan documents is valid unless and until you withdraw your consent in writing. You can opt out of electronic delivery at any time or change your email address and phone number by contacting the Administrative Office.
- You have the right to request hard copies of documents pursuant to ERISA section 104(b)(4). Send an email to info@carpenterssw.org or call (800) 293-1370 to request a hard copy of a document.
- If you have difficulty accessing any document, please contact the Administrative Office at info@carpenterssw.org or call (800) 293-1370. Many of the Trust Funds documents are also available on the CSAC website (www.carpenterssw.org). Please note that documents posted to the CSAC website may be taken down after one year or earlier if they are superseded by a new version.
- Standard message rates and data charges from the subscriber's carrier could apply when sending and/or receiving text messages.
- You may opt out of electronic delivery or change your contact information by submitting a new, signed form by:
  - Email to: enrollment@carpenterssw.org
  - Mail to: Southwest Carpenters Trust
    533 S. Fremont Avenue, 6th Floor
    Los Angeles, CA 90071

Signature _____ Date _____

Last Name	First Name	MI	Social Security Number

BENEFICIARY DESIGNATION*

Primary Beneficiary(ies)

List the person(s) who should receive your Life Insurance Benefit from the Health & Welfare Plan and your Vacation balance in the event of your death. If you are not married, this form will also apply to any earned Pension and/or Annuity benefit upon your death.

Name	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth

Secondary Beneficiary(ies)

Secondary Beneficiaries will be paid in the event that all Primary Beneficiary(ies) are deceased at the time of your death or the Administrative Office is unable to locate your Primary Beneficiary(ies).

Name	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth

Subject to the terms of the Trust Agreements for the Southwest Carpenters Health and Welfare Trust, the Southwest Carpenters Vacation Trust, the Southwest Carpenters Pension Trust and the Southwest Carpenters Annuity Trust, I request that any sum becoming payable to a beneficiary under said Trusts upon my death be payable to the beneficiaries listed above. I hereby revoke all designations of beneficiaries previously made by me under said Trusts.

Note: Plan rules dictate that your legal spouse will automatically be considered your Beneficiary for benefits from the Southwest Carpenters Pension Trust and that your legal spouse must consent in writing to the designation of a Beneficiary other than your spouse for the Southwest Carpenters Annuity Trust. Consult the Summary Plan Description (SPD) for more information on life insurance and/or survivor benefits for each Trust.

*** To add additional beneficiaries, to designate alternative beneficiaries by Fund and/or designate a Southwest Carpenters Annuity Trust beneficiary other than your spouse please go to www.carpenterssw.org to download Beneficiary Designation Form by Trust Fund. For assistance contact the Administrative Office at (213) 386-8590 or (800) 293-1370.**

Signature	Date

SOUTHWEST CARPENTERS HEALTH & WELFARE TRUST

MEDICAL/DENTAL ENROLLMENT

Social Security Number	Date of Birth (MM/DD/YYYY)	Gender (Check One)	M	F

Last Name	First Name	MI

Street Address	City	State	Zip Code

	Single		
	Married	Date of Marriage	/ /
	Separated	Date of Separation	/ /
	Divorced	Date of Dissolution	/ /
	Domestic Partner	Date of Domestic Partner Registration	/ /
	Widowed	Date of Death of Spouse	/ /

MARITAL STATUS

You must remove your ex-spouse or domestic partner (and any step-children) within 30 days of your divorce or the dissolution of your domestic partnership.

ACTIVE PLAN

Select your Medical and Dental Plan
Enrollment includes eligible dependents.

MEDICAL PLAN OPTIONS (CHECK ONE)

	SOUTHWEST CARPENTERS MEDICAL PPO PLAN ***(Available in all States)***
	KAISER PERMANENTE HMO PLAN ***(Available in CA & CO only)***

DENTAL PLAN OPTIONS (CHECK ONE)

	UNITED HEALTHCARE DENTAL PPO PLAN ***(Available in all States)***
	UNITED HEALTHCARE DENTAL DHMO PLAN **DC Plan (CA/NV) or INO Plan (AZ, CO, OR,WA, WY, UT)**

BRONZE MEDICAL PPO PLAN

Offered by Agreement
****Medical Coverage Only****
Dependents added with a monthly self payment
1 dependent =$150 per month
2 or more dependents = $250 per month

Apprentices default to Bronze Plan
AZ & CA – 1st and 2nd period / NV 1st-3rd period
Millwrights excluded

Drywall & Interior Systems Agreements in AZ, CO, ID, NM and UT
(Changing between the Active and Bronze Plan may result in a change to your base pay rate.)

	CHECK THIS BOX TO SELECT THE BRONZE MEDICAL PPO PLAN

ENROLLING DEPENDENTS

Spouse or Domestic Partner	Add / Remove		Social Security Number	Date of Birth			
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #1	Add / Remove		Social Security Number	Date of Birth			
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #2	Add / Remove		Social Security Number	Date of Birth			
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #3	Add / Remove		Social Security Number	Date of Birth			
Last Name	First Name		MI	Sex	Male / Female		
Dependent Child #4	Add / Remove		Social Security Number	Date of Birth			
Last Name	First Name		MI	Sex	Male / Female		

SOUTHWEST CARPENTERS HEALTH & WELFARE TRUST

MEDICAL/DENTAL ENROLLMENT

THE BELOW SECTION REQUIRES A SIGNTAURE FROM ALL PARTICIPANTS ENROLLING INTO ANY PLAN UNDER THE H&W TRUST.

To complete enrollment of your spouse/domestic partner and/or dependents, the following documents must be provided:

- Copy of Certified Marriage Certificate and your most recent tax return to enroll your spouse
- Copy of a Domestic Partnership Registration from a Government Agency and the Domestic Partner Enrollment Affidavit

  to enroll a Domestic Partner
- Copy of Certified Birth Certificate, Legal Guardianship, or Adoption Decree to enroll a dependent child

I hereby declare that all the statements made on the previous page are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance coverage may be issued. I agree on behalf of myself and the dependents listed that we are subject to the provisions of the applicable Summary Plan Description and all plan documents.

I understand that the Dental benefit plan I have selected provides reimbursement for certain Dental costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental expenses which I have incurred may not be covered by my Dental benefit plan. The Certificates provide Dental benefits only. Review your Certificates carefully.

FRAUD WARNING NOTICE: Providing false, incomplete or misleading information for any insurance policy shall not bar the right to recovery unless the statement was made with the actual intent to deceive, or it materially affects the acceptance of the risk or the hazard assumed by the insurers.

California law prohibits any HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Signature **(REQUIRED FOR ALL PARTICIPANTS)** Date

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Kaiser Foundation Health Plan, Inc., Arbitration Agreement*

THE BELOW SECTION REQUIRES A SIGNTAURE FROM PARTICIPANTS ENROLLING INTO KAISER ONLY.

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 **(REQUIRED ONLY FOR PARTICIPANTS ENROLLING IN KAISER)** Date

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