



WESTERN STATES CARPENTERS TRUSTS ENROLLMENT FORM

445 SOUTH FIGUEROA STREET, SUITE 1500

LOS ANGELES, CA 90071-3203

EMAIL TO: ENROLLMENT@CSACBENEFITS.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?	
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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		I consent to receive electronic delivery of Plan documents by email or text message.		
Yes	No			
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 sec on 104(b)(4). Send an email to info@csacbenefits.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@csacbenefits.org or call (800) 293-1370. Many of the Trust Funds documents are also available on the CSAC website (csacbenefits.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@csacbenefits.org
 - Mail to: Western States Carpenters Trusts
445 South Figueroa Street, Suite 1500
Los Angeles, CA 90071-3203

Signature

Date



WESTERN STATES CARPENTERS TRUSTS BENEFICIARY DESIGNATION

445 SOUTH FIGUEROA STREET, SUITE 1500
LOS ANGELES, CA 90071-3203

Participant Last Name	Participant First Name	MI	Participant Social Security Number
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List at least one Primary Beneficiary. If you list more than one Beneficiary and do not indicate the percentage allocation among them, benefits will be paid in equal shares. A Contingent Beneficiary applies only if all your Primary Beneficiary(ies) are deceased.

Primary Beneficiary(ies)

Name (First, Middle, Last)	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name (First, Middle, Last)	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name (First, Middle, Last)	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth

Contingent Beneficiary(ies)

Name (First, Middle, Last)	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth
Name (First, Middle, Last)	Relationship	Social Security Number	Benefit %
Address		Phone Number	Date of Birth

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

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

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

Signature	Date

**WESTERN STATES CARPENTERS HEALTH AND WELFARE TRUST
HEALTH CARE ENROLLMENT**

Social Security Number		Date of Birth (MM/DD/YYYY)		Gender (Choose One)		M	F
Last Name		First Name				MI	
Street Address		City		State		Zip Code	
Single				<p>You must remove your ex-spouse or domestic partner (and any step children) within 30 days of your divorce or dissolution of your domestic partnership.</p> <p>(WA Registered Domestic Partners are treated the same as Spouse)</p>			
Married		Date of Marriage					
Separated		Date of Separated					
Divorced		Date of Dissolution					
Domestic Partnership		Date of Domestic Partner Registration					
Widowed		Date of Death of Spouse					

WESTERN STATES CARPENTERS HEALTH AND WELFARE PLAN SELECTION

Coverage is subject to the health plan eligibility rules and the applicable labor agreement.

ACTIVE MEDICAL PLAN		BRONZE MEDICAL PLAN	
<p align="center"><i>Select your Medical Plan</i> Enrollment includes eligible dependents at no cost to you. **Dental and Vision plans are included in coverage.**</p>		<p align="center">Offered only by Agreement in AZ, CO, NM, UT, MT Making changes between the Active and Bronze Medical Plans may result in a change to your base pay rate.</p> <p align="center"><i>Apprentices default to the Bronze Plan by agreement: AZ & CA - 1st & 2nd period / NV - 1st thru 3rd period (Millwrights excluded)</i></p> <p align="center"><i>Dependents may be added with a monthly self-payment 1 - dependent +\$150 per month 2 - or more dependents +\$250 per month</i></p> <p align="center">**Dental and Vision plans are included in coverage.**</p>	
(CHOOSE ONE)			
<input type="radio"/>	<p>WESTERN STATES CARPENTERS MEDICAL PPO PLAN <i>(Available in all States)</i></p>	<input type="radio"/>	<p>SELECT THE BRONZE MEDICAL PPO PLAN</p>
<input type="radio"/>	<p>KAISER PERMANENTE PLAN <i>(Available in CA, CO, OR, and WA)</i> <u>Must reside in KP service area.</u></p>		

ENROLLING DEPENDENTS*

Spouse or Domestic Pt.	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female
Dependent Child #1	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female
Dependent Child #2	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female
Dependent Child #3	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female
Dependent Child #4	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female
Dependent Child #5	Add	Social Security Number	Date of Birth				
	Remove		MI	Gender	Male	Female	
Last Name		First Name		MI	Gender	Male	Female

Last Name	First Name	MI	Social Security Number
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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.

"It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

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.

Kaiser Plans in the NW and WA are offered by:

Kaiser Foundation Health Plan of Washington
2715 Naches Ave. SW, Renton, WA 98057

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2023

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

<i>Signature</i>	<i>Date</i>
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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.

<i>Signature</i>	<i>Date</i>
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* Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

***Dependent Eligibility**

- Dependents are not required to reside with the subscriber.
- Dependents are not required to be dependent upon the subscriber for support.
- Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments.
- Dependent children are eligible for coverage through the age of 25 regardless of marital status, or eligibility for coverage under another plan.

If children of the primary insured are covered, children of Domestic Partners are eligible for coverage on the same basis.