MEDICAL OPTION FORM

Send completed form to: **Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119**

Please enroll me in the Medical Plan Option checked below.
I understand that my choice will apply to me and to* all *my eligible dependents:

- ☐ Indemnity Medical Option (Includes Blue Cross PPO network)
- ☐ Kaiser Foundation Health Plan (HMO)
- ☐ United HealthCare (HMO)

Note: You may enroll in PacifiCare if you and your eligible dependent/s live or work within 30 miles of a United HealthCare participating Primary Care Physician, or for Kaiser, within 30 miles of a Kaiser facility.

If you choose HMO coverage, you *must* return this form and your HMO application. For a Kaiser or United HealthCare packet and application, phone the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119.

If HMO: ☐ **My completed HMO application is enclosed.**

Employee's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female
Spouse's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female

Address *Please Print*	City	State	Zip Code

Work Phone ( )	Home Phone ( )	

Your Employer	Date Hired (Month-Day-Year)	Local Union Number

ELIGIBLE MINOR DEPENDENTS **(as listed on my TBT *Enrollment Form*)**
Please list additional eligible dependents on the back.

Dependent's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female
Dependent's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female
Dependent's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female
Dependent's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)	☐ Male ☐ Female

Employee's Signature	Date (Month-Day-Year)

If you have not yet returned the TBT Enrollment Form (available at www.tbtfund.org or in your *Enrollment Materials* folder), please do so now. **Note:** Every participant MUST have a *TBT Enrollment Form* on file as well as this *Medical Option Form* (and an *HMO Application* if you choose an HMO).

Return *all* items to: **Teamsters Benefit Trust, P.O. Box 5820, Fremont, CA 94537-5820**

NOTE: DO NOT SEND HMO APPLICATIONS DIRECTLY TO THE HMO!