TEAMSTERS BENEFIT TRUST (TBT)

MEDICAL OPTION CHANGE FORM

For Plan I, I-A, I-85, III, III-A, III-NEWS, IV, V (Five), V-A, V-A-NEWS, VI and A Employees and Dependents

COMPLETE THIS FORM ONLY IF YOU ARE MAKING A CHANGE IN YOUR MEDICAL OPTION. Otherwise, your current medical coverage continues without change.

PLEASE ENROLL ME IN THE MEDICAL OPTION DESIGNATED BELOW.
I understand that coverage under the new option for me and my eligible dependents is **effective the first day of the second month following receipt by the TBT Plan Administration Office**, (including changes to an HMO, whether or not I receive a membership card from an HMO by that date). **Note:** *You and your eligible dependents must be covered under the same medical option.*

☐ Indemnity Medical Option (described in your Plan's *Guide to Your Benefits* and *Summary of Coverage*)
☐ Kaiser Foundation Health Plan (HMO) *(Include attached Kaiser HMO application)*
☐ *PacifiCare* (HMO) (*Not available for Plan VI*) *(Include attached PacifiCare HMO application)*

RESIDENCE: In order to change from the Indemnity medical option to an HMO, or from one HMO to another, you and your dependents must reside within the HMO's service area. *(Service areas are listed in the HMO packets.)*

If electing an HMO:

- Include the applicable attached HMO application (late receipt may delay your change).
- For HMO packets and applications, call the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119 and ask to speak with someone in the Open Enrollment Unit.

IF MAKING A CHANGE, ALSO PROVIDE THE FOLLOWING INFORMATION:

Employee's Name (Last, First, Middle Initial) *Please Print*	Social Security Number	Birth Date (Month-Day-Year)
Spouse's Name	Social Security Number	Birth Date (Month-Day-Year)
Address		Home Phone ( )
Your Employer	Date of Hire	Local Union

ELIGIBLE MINOR DEPENDENTS (as listed on my TBT *Enrollment Form*) Use back for additional dependents.

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

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

Employee's Signature	**Date**

Call the TBT Plan Administration Office at (510) 796-4676 or (800) 533-0119 to discuss your individual needs. Please ask to speak with someone in the Open Enrollment Unit.

If you are changing options, please return *this form* and *an HMO application* (if electing an HMO) **to:**

Teamsters Benefit Trust - P.O. Box 5820, Fremont, CA 94537-5820
(pre-addressed envelope enclosed)

Note: *Do <u>not</u> send HMO applications directly to the HMO!*