

MEDICAL / DENTAL OPTION INFORMATION ORDER FORM

Date	Social Security Number	Employer		
Name (Please Print)		Phone Number ()		
Address (Please Print)		City	State	Zip Code

ITEMS REQUESTED

- MEDICAL:** Please send me a **Medical Option Change Form** and the following items:
Note: All HMO packets include applications.
 - Kaiser Foundation Health Plan packet (HMO—Actives and Pre-Medicare Retirees in California)
 - Kaiser Senior Advantage packet (HMO—Medicare Retirees in California)
 - Anthem Blue Cross HMO packet (Actives and Non-Medicare Retirees in California—except Plan VI)
 - United HealthCare Medicare Advantage HMO packet (Medicare Retirees in California—except Plan VI)
- DENTAL:** Please send me a **Dental Option Change Form** and the following items:
Note: Actives and RSP participants only.
 - Bright Now! / Newport Dental* brochure
 - Delta Dental brochure
 - UHC Select Managed Care brochure
- BROCHURES:** Please send me the following TBT medical and/or dental benefits items:
 - Comparison of Dental Benefits (Active and RSP participants only)
 - Comparison of Medical Benefits
 - Summary of Coverage

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

SEND the completed form in one of these ways:

- Fax to TBT at (510) 795-9237

- E-mail to enroll@lipmantpa.com

- Mail or bring to: **TBT Plan Administration Office, 39420 Liberty Street, Suite 260, Fremont CA 94538**

All completed change request forms and applications (including HMO Plan applications) must be sent to TBT.
Do not send anything directly to an HMO or dental provider!