TEAMSTERS BENEFIT TRUST (TBT)

MEDICAL OPTION CHANGE FORM

For Plan I, I-A, I-85, III, III-A, IV, V (Five), V-A, and VI
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 Kaiser HMO application)*
☐ Anthem Blue Cross HMO (*Not available for Plan VI*) *Include* Anthem Blue Cross *HMO application)*

RESIDENCE: 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 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.

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 forms must be sent to TBT.
DO NOT SEND HMO APPLICATIONS DIRECTLY TO THE HMO!