ILWU-PMA WELFARE PLAN
MEDICARE CLAIM FORM FOR SUPPLEMENTAL HOSPITAL, MEDICAL, SURGICAL BENEFITS

(For Retirees, their Dependents or Survivors Enrolled Under Part A and Part B of Medicare)

ILWU-PMA COASTWISE CLAIMS OFFICE

☐Retired
☐ Survivor

1. **IDENTIFICATION** EMPLOYEE'S NAME: _____

   Date of Birth: _____ Local Number: _____ Registration Number: _____

   If claim is for Spouse, insert SPOUSE'S NAME: _____

2. **EXPLANATION:** Medicare will send you a record of the action taken on your Medicare claim – A **Record of Hospital Benefits used under Medicare**, or an **Explanation of Benefits, Medical Insurance.** The Medicare notice(s) must be submitted with this claim.

   TO COMPLETE THIS CLAIM, fill in Part 1, Sign the Authorization (Part 10). If you want payment made directly to the hospital or doctor even when claim is for your spouse, complete and sign the*Optional Assignment (Part 11).*

3. Is the patient covered by any other Group Insurance or Health Services Plan? Yes ☐ No☐

   If Yes, what is the Policy Number: _____, Name of Other Plan: _____

   Address of Other Plan: _____
   (Address) *(City & State)* *(Zip Code)*

4. Is patient's condition due to an accident, injury, or illness arising out of employment? Yes ☐ No ☐	5. If answer to #4 is yes, have you or the patient filed, or do you intend to file, a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
6. Is patient's condition due to an accident, injury, or illness cause by some other party? Yes ☐ No ☐	7. If answer to #6 is yes, have you or the patient filed, or do you intend to file, any legal action or claim against the other party? Yes ☐ No ☐
8. Is patient's condition due to an accident? Yes ☐ No ☐	9. If answer to #8 is Yes, how, where, and date.

10. The above answers are true and complete to the best of my knowledge and belief, I authorize any physician, medical institution druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE as is required to properly pay all benefits, if any due for this claim.

    Employee Signature: _____ Date: _____

    Patient (or if Minor, a Parent): _____ Date: _____

(OPTIONAL)

11. **ASSIGNMENT OF BENEFITS:** I hereby assign benefits due me to the extent of expenses incurred and payable for injury or illness commencing _____, 20_____ to the following:

    Hospital: _____

    Doctor: _____

    Other: _____

    Date: _____ Signed: _____
    (Insured Employee / Survivor)

HOW TO FILE YOUR CLAIM:

(1) Attach Medicare Notice(s);
(2) Mail to: ILWU-PMA COASTWISE CLAIMS OFFICE
P.O. Box 429101
San Francisco, CA 94142

Employer Group Use Only
Please, provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: 101035T

Employer Receipt Date: ___/___/____

Authorized Rep:

Please contact Kaiser Permanente if you need information in another language or accessible format (Braille).

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information

Employer or Union Name: IUOE-PMA

Group #: 101035T

LAST Name:

☐ Mr. ☐ Mrs. ☐ Ms.

FIRST Name:

Middle Initial:

Sex: ☐ Male ☐ Female

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

Permanent Residence Street Address (P.O. Box is not allowed):

City:

County:

State:

ZIP Code:

~~Home Phone Number:~~

~~Alternate Phone Number:~~

~~Birth Date: (mm/dd/yyyy)~~

Mailing Address (only if different from your Permanent Residence Address)

Street Address:

City:

State:

ZIP Code:

E-mail Address:

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	__/__/____
MEDICAL (Part B)	__/__/____

You must have Medicare Part B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you or your spouse work? ☐ Yes ☐ No

2. If your employer provides retiree coverage, are you the retiree? ☐ Yes ☐ No ☐ N/A
   If yes, retirement date (mm/dd/yyyy): __/__/____
   If no, name of retiree: _____ Retirement date (mm/dd/yyyy): __/__/____

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse: _____
   Name(s) of dependent(s): _____

4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.
   Will you have other prescription drug coverage in addition to Kaiser Permanente? ☐ Yes ☐ No
   If yes, please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: _____ ID # for other coverage: _____

Last Name First Name

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If yes, please provide the following information:
   Name of institution:
   Address of institution (number and street): Phone Number: - -

7. Requested effective date (subject to CMS approval): / /

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Large Print ☐ Braille ☐ CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

Please complete the information below

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name: ILWU-PMA

Employer Group/Union/Trust Fund ID #: 101035 Subgroup: --- Requested effective date (subject to CMS approval): / /

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227** or TTY **1-877-486-2048)**, 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Last Name _____ First Name _____

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage **Evidence of Coverage** document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency, urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

Release of Information

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Last Name First Name

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that, if I select a health insurance plan ("health plan") that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the health plan (except for Small Claims Court cases, claims governed by the ERISA claims procedure regulation, and other claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the health plan, any contracted health care benefit providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the health plan, 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 in the health plan's coverage document, which is available for my review.

Signature:

Today's Date: / /

If you are the authorized representative, you must sign above and provide the following information:

Name:

Address:

Phone Number: - - Relationship to Enrollee:

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment):

Plan ID #: Effective Date of Coverage: / /

ICEP/IEP: AEP: SEP (type): Not Eligible: