ENROLLMENT FORM

BAY AREA DELIVERY DRIVERS SECURITY FUND, 4160 DUBLIN BLVD., SUITE 400, DUBLIN, CA 94568-7756
PHONE: 1-800-654-1824 FAX: (925) 833-7301

TYPEWRITTEN OR PRINTED IN INK ONLY

1. SOCIAL SECURITY NUMBER	2. NAME (Last) (First) (Middle)	3. DATE OF BIRTH MONTH / DAY / YEAR	SEX MALE ☐ FEMALE ☐
4. ADDRESS (NUMBER)	(STREET)	LOCAL NO. ________ EMPLOYER: ________	
5. CITY	STATE ZIP CODE	6. PHONE ( ) ________	

CHOICE OF PLANS

MEDICAL SELECTION – CHOOSE ONE:

☐ Bay Area Delivery Drivers Security Fund Indemnity Plan (BADD) ☐ Kaiser

DEPENDENT INFORMATION

7. Please complete the following dependent enrollment information. If married, you must provide a copy of your marriage certificate. If you have eligible children, you must provide a birth certificate for each child. Your dependents will not be enrolled until this information is provided. If your child is adopted or if you are a court-appointed guardian, please submit adoption papers or court papers establishing your legal guardianship in lieu of birth certificate. Please indicate if you are enrolling a stepchild by writing "step" in the relationship box. See additional information on back.

FULL FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	SOCIAL SECURITY NO. (MUST BE PROVIDED)	RELATIONSHIP			
					Spouse	Son	Daughter	Other*
A.								
B.								
C.								
D.								

*If you have checked "Other", please explain: ________

8. If you have more than 4 dependents, check here ☐ and see instructions on back page.

9. Does anyone listed on this form have health insurance through another source? ☐ YES ☐ NO
   If Yes, name of other coverage and persons covered: ________

BENEFICIARY INFORMATION

10. Death Benefits are to be paid to:
    Give person(s) full Legal Name and Relationship. If a minor, also list Guardian. The person(s) named will be considered your beneficiary unless you specify otherwise.

NAME ________ RELATIONSHIP ________ ________ %

NAME ________ RELATIONSHIP ________ ________ %

▪ I understand that all questions must be answered before Bay Area Delivery Drivers Security Fund can consider this enrollment request. ▪ I have read and understand the requirements, terms, conditions, limitations, provisions, and other information discussed in the enrollment materials. ▪ For the purposes of processing claims for benefits, on behalf of myself and enrolling family members, I AUTHORIZE the release and exchange of full information regarding school enrollment, medical history, consultation, or treatment, including copies of all records between and among all doctors, dentists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs or supplies, and any insurance carrier, service plan, union, trust fund, provider network, school, or employer, to the extent permitted by law. ▪ I declare that the statements contained in this enrollment form are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted. ▪ **I understand that it is illegal, and is a felony in some states, for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an enrollment request containing any false, incomplete, or misleading information. In some states, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits.**

Members Signature	Date Signed	☐ Marriage Certificate Attached ☐ Birth Certificate(s) Attached ________(number)

Each participant must notify the Administrative Office promptly when any change occurs in family status due to marriage, birth of a child, death, dissolution of marriage (divorce) or change of beneficiary. A new Enrollment Form must be completed and mailed to the Administrative Office when a change occurs.

Dear Participant:

You should carefully complete this enrollment form and fill in the required information as neatly and clearly as possible. This information is an important part of your official record with the Fund. Most of the items clearly indicate the information required; however, instructions are listed below for those items which might need explaining.

ITEM 1 Fill in your Social Security Number as it appears on your Social Security card.

ITEM 3 Please fill in the month, day and year of your birth. The year alone is not enough.

ITEM 7 The Fund has the right to request proof of marriage, of divorce, or of birth to verify the information given and to determine the eligibility of a dependent for enrollment.

Eligible dependents are:

I. Your lawful spouse. In the event of a final dissolution of your marriage (divorce), the spouse is no longer eligible for coverage and you should immediately complete and mail a new enrollment form to the Fund Office to delete your spouse as your dependent. If you fail to do so, you may be held responsible for repayment of any benefits provided to which your former spouse is no longer entitled.
(CERTIFICATION REQUIRED: Certified Marriage Certificate, recorded final marriage dissolution document.)

II. Your domestic partner. Your domestic partner must be of the same gender unless you or your domestic partner is over age 62: opposite sex domestic partners are covered if either of you are over age 62. (Refer to pages 5-6 of the Summary Plan Description for registration requirements.)
(CERTIFICATION REQUIRED: A copy of your notarized Declaration of Domestic Partnership that you have filed with the Domestic Partner Registry of California's Secretary of State, and a copy of the Certificate of Domestic Partnership issued to you and your domestic partner by the Secretary of State.)

III. Your unmarried children under age 19 who primarily depend on you for financial support or for whom you must contribute support by order of the court. Stepchildren and adopted children entirely supported by the participant are also included.
(CERTIFICATION REQUIRED: Birth Certificate, Legal Guardianship papers.)

IV. Your unmarried children under age 24 provided they primarily depend on you for financial support and they are attending an accredited school or college as a full-time student.
(CERTIFICATION REQUIRED: Full-time student verification.)

V. An unmarried child of any age who is unable to earn a living because of a disability is also considered an eligible dependent, provided the child was both disabled and eligible under the Fund before reaching age 19 and provides proof of disability before reaching age 19.
(CERTIFICATION REQUIRED: Physician Statement.)

ITEM 8 If you have more than 4 eligible dependents obtain an additional enrollment form and mark it "FORM 2" at the top. On Form 2, complete items 1 through 6 then list your additional dependents under item 8.

ITEM 11 Be sure to sign and date this form and return it to the Trust Fund Office. Also, be certain you have listed all dates of birth correctly.

AFTER YOU HAVE COMPLETED THE REVERSE SIDE OF THIS FORM, RETURN IT TO:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756