ENROLLMENT FORM
FOR SEASONAL MEDICAL BENEFITS PLAN EMPLOYEES

JOINT BENEFIT TRUST • 4160 DUBLIN BLVD., SUITE 400 • DUBLIN, CALIFORNIA 94568

TYPE WRITTEN OR PRINTED IN INK ONLY

PLEASE READ CAREFULLY: This enrollment form is to be completed and signed by the employee only and all requested information must be provided. Applications containing illegible, missing or incomplete information will not be accepted. All information appearing on your application for coverage is subject to verification and periodic audit. Applications containing false, inaccurate or misleading information (including omissions) will be grounds for denial of some or all benefits available under the Trust. In the event that benefits are granted based on information that is later determined to be inaccurate, false or misleading, Joint Benefit Trust reserves the right to renew certificates of marriage and any other documentation of dependent relationships as well as the right to recover any and all funds paid as the result of the fraudulent information, as authorized by law.

I have read and understand the above: _____ _____
EMPLOYEE'S SIGNATURE DATE

1. SOCIAL SECURITY NUMBER	2. NAME (Last) (First) (MIDDLE)	3. SEX FEMALE ☐ MALE ☐	4. LOCAL
5. DATE OF BIRTH (Mo./Day/Yr.)	6. EMAIL ADDRESS (Optional)	7. HOME PHONE ( ) Area Code	
8. ADDRESS (NUMBER) (STREET)		9. CELL PHONE ( ) Area Code	10. RECEIVE TEXT MSG? YES / NO
11. CITY STATE ZIP CODE		12. ADDRESS CHANGE YES / NO	13. WORK PHONE ( ) Area Code

DEPENDENT INFORMATION

14. Please complete the following dependent enrollment information. **Spouses are not covered under the JBT Seasonal Medical Benefits Plan.** 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 certificates. Please indicate if you are enrolling 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 Son	Daughter	Other*
A.								
B.								
C.								
D.								

*if you have checked "Other", please explain _____

15. If you have more than 4 dependents, check here ☐ and see instructions on back page.
16. Does anyone listed on this form have health insurance through another source? ☐ YES ☐ NO
If Yes, name of other coverage and persons covered: _____

PLAN SELECTION

The JBT Indemnity Plan will pay a percentage of your expenses after an annual deductible is met and a participating network provider is used. **If you do not make a Plan selection or if you first become eligible under JBT on or after October 1, 2022, you will automatically be enrolled in the Advantage Network.**

☐ Advantage PPO Network - This option does **NOT** cover services provided by a Sutter Health hospital or physician.

☐ Prudent Buyer PPO Plan - This option covers services provided by a Sutter Health hospital or physician and will have a higher co-contribution. This option is only available if you first became eligible under JBT before October 1, 2022.

17. I certify that all statements and information provided by me represents a complete and truthful disclosure and that each individual named on this form is my true and legal dependent child (ren).

X_____ _____
EMPLOYEE'S SIGNATURE DATE

Each participant must notify the Administrative Office promptly when any change occurs in the family status due to the birth of a child, death 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 5 Please fill in the month, day and year of your birth. The year alone is not enough.

ITEM 10 Mark "NO" if you do not want to receive important benefit notifications via text message.

ITEM 14 The fund has the right to request proof of birth to verify the information given and to determine the eligibility of a dependent for enrollment**.**

Eligible dependents are:

I. Your children under age of 26. (**CERTIFICATION REQUIRED**: **Birth Certificate, Legal Guardianship papers.)**

II. A 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 26 and provides proof of disability before reaching age 19. (**CERTIFICATION REQUIRED**: **Physician Statement**.

ITEM 15 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 13 then list your additional dependents under item 14.

ITEM 17 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 TO:

Joint Benefit Trust
4160 Dublin Blvd., Suite 400
Dublin, CA 94568