OLAM ENROLLMENT FORM
FOR FULL-TIME HEALTH 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. CITY STATE ZIP CODE	11. ADDRESS CHANGE YES / NO	12. WORK PHONE ( ) Area Code	

DEPENDENT INFORMATION

13. Please complete the following dependent enrollment information. 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			
					Spouse	Son	Daughter	Other*
A.								
B.								
C.								
D.								

*if you have checked "Other", please explain _____
14. If you have more than 4 dependents, check here ☐ and see instructions on back page.
15. 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. **You must select one of the following Plan Networks at the time of enrollment. If you do not make a Plan selection, 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 (only available to employees who first became eligible prior to October 1, 2022) - This option covers services provided by a Sutter Health hospital or physician and will have a higher co-contribution.

☐ Kaiser Permanente - This option is only available IF you live within a Kaiser Permanente region. Call 1-800-464-4000 to verify region.

16. 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

BENEFICIARY INFORMATION

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

NAME(S)_____RELATIONSHIP_____

ADDRESS_____

BIRTH DATE_____ SOCIAL SECURITY NUMBER_____

If Beneficiary is a minor, please provide name of Guardian_____

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 The fund has the right to request proof of birth to verify the information give 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 children under age of 26. (**CERTIFICATION REQUIRED**: **Birth Certificate, Legal Guardianship papers.)**

III. 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 14 If you have more than 4 eligible dependents, obtain an additional enrollment form and mark it “FORM2” at the top. On Form 2, complete items 1 through 12 then list your additional dependents under item 13.

ITEM 16 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