EMPLOYEE CHANGE FORM

TEAMSTERS MULTI BENEFIT TRUST

EMPLOYEE INFORMATION (PLEASE TYPE OR PRINT CLEARLY.)

EMPLOYER NAME	UNIT NO	EFFECTIVE DATE

Social Security Number	Last Name	First Name	MI

Employee address	City	State	zip Code	Employee Phone No.

Date Of Birth	Sex	Married	Date Of Hire	UNION ☐ Yes ☐ No	Union Local

Primary Care Physician	**Existing Patient (Y/N)**	**Medical Group Number**	**Provider Number**

TYPE OF CHANGE (SELECT THE TYPE OF CHANGE)

☐ **Add Dependent(s)** ☐ **Delete Dependent(s)** ☐ **Change of Address** ☐ **Change Health Plans** ☐ **Other**_______________

☐ **Medical Plan** **Dental Plan** **VISION PLAN**

FAMILY INFORMATION (LIST BELOW THE DEPENDENTS YOU WISH TO ENROLL)

Kaiser applicants do not need to list a Primary Care Physician
Your Dependent's Social Security Number is required by Federal Law

SPOUSE

First Name	**MI**	**Last Name**	**Date of Birth**	**Sex**	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Medical Group Number**	**Provider Number**

CHILD

First Name	**MI**	**Last Name**	**Date of Birth**	**Sex**	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Medical Group Number**	**Provider Number**

CHILD

First Name	**MI**	**Last Name**	**Date of Birth**	**Sex**	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Medical Group Number**	**Provider Number**

CHILD

First Name	**MI**	**Last Name**	**Date of Birth**	**Sex**	**Social Security No**

Primary Care Physician	**Existing Patient (Y/N)**	**Medical Group Number**	**Provider Number**

DENTAL COVERAGE

Name of Dentist/Dental Office	**Participating Dental Provider Number**

The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, section 56 et seq. of the California Civil Code. Your cooperation is requested.

Authorization to obtain or release medical information: I hereby authorize my physician, healthcare practitioners, hospital, clinic or other medically related facility to furnish to the Health Plan selected above, or its representatives or designee, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal (including the release to an independent review organization) or grievance, or for preventative health or health management purposes.

I authorize the Health Plan selected above, or its representative or designee, to disclose to the hospital or healthcare service plan, self- insurer, any such medical information obtained in such disclosure if necessary to allow the processing of any claim.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and the Health Plan selected above, any affiliated companies, or any Participating Physician Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

Signature of Employee____ **Date** ______________________

Teamsters Multi -Benefit Trust
Administered By: Benefit Programs Administration
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