

MEDICAL OPTION FORM

Send completed form to: Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119

Please enroll me in the Medical Plan Option checked below.

I understand that my choice will apply to me and to all my eligible dependents:

- Indemnity Medical Option (as described in the *Summary of Coverage and Guide to Your Benefits*)
- Kaiser Foundation Health Plan (HMO)*
- Health Net (HMO)*
- PacifiCare (HMO)* (formerly FHP HealthCare)

* Note: You may choose an HMO *only if you live within that HMO's service area.*

If you choose HMO coverage, you *must* return this form and your HMO Application. A Kaiser packet and application are enclosed. For Health Net and PacifiCare packets and applications, phone the Plan Administration Office at (510) 796-4676 or (800) 533-0119.

If HMO: My completed HMO application is enclosed.

Employee's Name (Last, First, Middle Initial) <i>Please Print</i>		Social Security Number		Birth Date (Month-Day-Year)	
Spouse's Name (Last, First, Middle Initial) <i>Please Print</i>		Social Security Number		Birth Date (Month-Day-Year)	
Address <i>Please Print</i>		City		State	Zip Code
Work Phone ()		Home Phone ()			
Your Employer		Date Hired (Month-Day-Year)		Local Union Number	

ELIGIBLE MINOR DEPENDENTS (as listed on my TBT *Enrollment Form*)

Please list additional eligible dependents on the back.

Dependent's Name (Last, First, Middle Initial) <i>Please Print</i>	Social Security Number	Birth Date (Month-Day-Year)
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Employee's Signature	Date (Month-Day-Year)
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If you have not yet returned the TBT Enrollment Form (the tear-out form in Your *Enrollment Materials*), please do so now. **Note:** Every participant **MUST** have a *TBT Enrollment Form* on file as well as this *Medical Option Form* (and an *HMO Application* if you choose an HMO).

Return *all* items to: **Teamsters Benefit Trust, P.O. Box 5820, Fremont, CA 94537-5820**

A pre-addressed envelope is enclosed.

NOTE: DO NOT SEND HMO APPLICATIONS DIRECTLY TO THE HMO!