Los Angeles Machinist Benefit Trust
Health & Welfare

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Phone: (800) 499-8121
FAX: (925) 833-7301

Website
www.lambt.org

RETIREE ENROLLMENT FORM

PLEASE INDICATE YOUR SELECTION

This form does NOT need to be completed if you make no change to your benefits.
If you do make changes, please select only the change you want to make.

Health Coverage (Choose One):
- ☐ Kaiser Permanente - High Option
- ☐ Kaiser Permanente - Low Option
- ☐ Blue Shield - High Option
- ☐ Blue Shield - Low Option

Optional Vision Plans (Choose One):
- ☐ Vision - Medical Eye Services
- ☐ Vision - Vision Services Plan $5 Copay
- ☐ Vision - Vision Services Plan $5 Copay with Lens Option

Optional Dental Plan - ☐ CIGNA (DHMO)

RETIRED EMPLOYEE

Last Name _____ First Name _____ MI _____

Birth Date (mm/dd/yyyy) _____ Social Security Number _____

Mailing Address (Street/PO Box) _____ City _____ State _____ ZipCode _____

Name of Employer at Time of Retirement _____ Hire Date _____ Last Day of Work _____

Are you currently eligible for Medicare A and B? ☐ No ☐ Yes

If yes, Medicare effective date: _____

Medicare HICN: _____

Are you eligible for medical benefits from any other group plan? ☐ No ☐ Yes

If yes, name of the group plan: _____

SPOUSE

Last Name _____ First Name _____ MI _____

Birth Date (mm/dd/yyyy) _____ Social Security Number _____

Is your spouse currently eligible for Medicare A and B? ☐ No ☐ Yes

If yes, Medicare effective date: _____

Medicare HICN: _____

Is your spouse eligible for medical benefits from any other group plan? ☐ No ☐ Yes

If yes, name of the group plan: _____

If you wish to enroll, you must return this form. Failure to pay contributions when they are due will lead to termination of benefits.

☐ I decline coverage in ALL coverage options.
Explanation:

SIGNATURE(S)

Retiree Signature _____ Date _____

Spouse Signature _____ Date _____