LOS ANGELES MACHINIST
BENEFIT TRUST
Health & Welfare

221 MAIN STREET SUITE 250, SAN FRANCISCO CALIFORNIA 94105-1956
PHONE: 800-499-8121 • FAX: 323-728-2982 • 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

- ☐ Kaiser Permanente – High Option
- ☐ Kaiser Permanente – Low Option
- ☐ Blue Shield – High Option
- ☐ Blue Shield – Low Option
- ☐ Dental – United Concordia
- ☐ Vision – Medical Eye Services
- ☐ Vision – Vision Services Plan $5 Copay
- ☐ Vision – Vision Services Plan $5 Co-pay with Lens Option

RETIRED EMPLOYEE

Last Name _____ First Name _____ MI _____

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

Mailing Address (Street / P O Box) _____ City _____ State _____ ZIP Code _____

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/yy) _____ 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 change your enrollment option, you must return this form. If you do not wish to make changes, this form is optional. Failure to pay contributions when they are due will lead to termination of benefits.

☐ I decline coverage and wish to cancel my participation in ALL coverage options.

Explanation:

SIGNATURE(S)

Retiree Signature _____ Date _____

Spouse Signature _____ Date _____