UNITED FOOD AND COMMERCIAL WORKERS UNION
AND PARTICIPATING FOOD INDUSTRY EMPLOYERS
HEALTH AND WELFARE FUND
800-228-7484 856-793-2500 Fax- 1-856-793-3100

HEALTH INSURANCE COVERAGE INFORMATION FORM

SECTION I ☐ PLEASE COMPLETE THE FOLLOWING INFORMATION (print or type):

LAST NAME	FIRST NAME	MIDDLE INITIAL	__Male __Female
STREET ADDRESS		APT. NO.	
CITY, STATE, ZIP CODE		DATE OF BIRTH	
HOME PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	EMPLOYER	LOCAL UNION NUMBER

PRESENT STATUS: Single___ Married___ Divorced___ Separated___ ___ Other (explain on reverse side)

LIST BELOW NAME(S) OF YOUR SPOUSE AND ELIGIBLE DEPENDENT CHILDREN (use reverse side if necessary)

NAME First	NAME Last (if different)	SEX	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YR	RELATIONSHIP	SOCIAL SECURITY NUMBER
						Husband Wife	
						Child Stepchild	
						Child Stepchild	
						Child Stepchild	

SECTION II ☐ PLEASE COMPLETE THE FOLLOWING INFORMATION:

1. **Do you have other medical coverage available through another source?** __YES __NO
   If YES, please check box Spouse__ Parent__ Other Employer__ Medicare__ Medicaid__
   If you do have other Medical Benefits, please list the name of the insurer.

   _____ _____ _____
   INSURANCE COMPANY EFFECTIVE DATE EMPLOYER

2. **Does your spouse or children have medical coverage through another source?** __ YES __ NO
   If YES, please check box Spouse__ Parent__ Other Employer__ Medicare__ Medicaid__
   If you do have other Medical Benefits, please list the name of the insurer.

   _____ _____ _____
   INSURANCE COMPANY EFFECTIVE DATE EMPLOYER

3. **Were you offered or do you have the opportunity to purchase other Group Health Insurance?** __YES __NO
   If YES, please check: Spouse___ Parent___ Other Employer___

   Approximate cost weekly $_____ Approximate cost monthly $_____

SECTION III ☐ PLEASE SIGN AND RETURN THIS FORM IN THE ENCLOSED SELF-ADDRESSED ENVELOPE IMMEDIATELY:

_____ _____
YOUR SIGNATURE **DATE**