a VOICE for working America

United Food and Commercial Workers Union and Participating Food Industry Employers Tri-State Health and Welfare Fund



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ENROLLMENT INFORMATION FORM - ACTIVE PARTICIPANT

	Employee Informati									
This section	n requires informatio	n about y	oout you, the employee/participant.			Please complete each area.			h area.	
Employee (Participant) Last Name		Firs	First Name/Middle Initial		Sex	Date of Birth		Socia	Security Number	
					OM OF	1 1				
Employee (Participant) Address		City	City / State Zip					Phone Number		
Name of Employer		☐ Full time Marital		Marital Status:			Local		Date of Hire	
		☐ Part tim		☐ Married ☐ Divorced	☐ Separated	Union			111	
		U COA		1 Divorced		Number			1 1	
Section 2	Danandani 9 Ingura	and Info		A CONTRACTOR OF THE		00000000	Maria Maria			
Section 2 - Dependent & Insurance Information This section requires detailed information about you and your dependents, other employment and										
other group	insurance coverage		, abou	at you and yo	ar depende	ms, or	ner emp	noyiiic	nt and	
Vourcelel	Yourself/ Last Name, First N		e.	Middle Initial	Sex	Date of Birth		Socia	Security Number	
Participant					DW D5	, ,				
	tress of other Employer if	annlicable			OM OF	1				
Name and Address of other Employer if applicable										
Doos the person	on listed above have cove	rago availal	alo thro	ugh any plan of	hor than the LIE	ECW Tri	State Her	Ith 2 \A/	olfaro Eund (athor	
employment, a	a spouse's employer, a par ance company or union.	ent, Medica	are, etc)? Check the typ	e of benefit that	at the ot	her plan w	ill cover	and the name of	
Hospitalizati	on: Medical/Surgery	Major Med	dical	Drug Card o	r Prescription E	Benefit	Dent	tal	Vision	
			'es □ No □ Yes			☐ Yes		□ No	☐ Yes ☐ No	
Name and Address of Other Insurance Company Is this an HMO? ☐ Yes ☐ No										
	Last Name,	First Nam	e.	Middle Initial	Sex Date of Birth		Social Security Number			
Spouse					DMDE					
Name and Add					1	1				
Name and Add	iress of Employer									
employment, a	on listed above have cove a spouse's employer, a par ance company or union.	rage availal ent, Medica	ole thro	ough any plan ot)? Check the typ	ner than the UF be of benefit tha	CW Triest the ot	-State Hea	alth & W	elfare Fund (other and the name of	
		Major Med ☐ Yes ☐				Benefit Dental			Vision ☐ Yes ☐ No	
Name and Address of Other Insurance Company Is this an HMO? ☐ Yes ☐ No										
	Last Name,	First Nam	e,	Middle Initial	Sex	Date	of Birth	Socia	Security Number	
Child					DM DF	1	1			
Name and Add	Iress of Employer				UIVI UF	- /				
and ride										
employment, a	on listed above have cover spouse's employer, a par ance company or union.	rage availal ent, Medica	ole thro	ough any plan ot)? Check the typ	ner than the UF e of benefit tha	CW Triat the ot	-State Hea	alth & W	elfare Fund (other and the name of	
Hospitalizati	Major Med			r Prescription Benefit Dent Yes No			Carlot Account of the Control of the	Vision ☐ Yes ☐ No		
Name and Address of Other Insurance Company Is this an HMO?									Is this an HMO?	
									☐ Yes ☐ No	



Continued Enrollment Information Form

Em omnem	IIIIOIIIIatioii Foili				As a second of the second				
Child	Last Name,	First Name,	Middle Initial	Sex	Date of Birth	Socia	I Security Number		
				DM DF	1 1				
Name and Address of Employer									
Does the person listed above have coverage available through any plan other than the UFCW Tri-State Health & Welfare Fund (other employment, a spouse's employer, a parent, Medicare, etc)? Check the type of benefit that the other plan will cover and the name of the other insurance company or union.									
	on: Medical/Surgery Yes 🗆 No	Major Medical ☐ Yes ☐ No	Drug Card o		Dental Vision ☐ Yes ☐ No ☐ Yes ☐ No				
Name and Address of Other Insurance Company Is this an HMO? ☐ Yes ☐ No									
Child	Last Name,	First Name,	Middle Initial	Sex	Date of Birth	Socia	l Security Number		
Name and Add	lress of Employer				1 1				
Does the person listed above have coverage available through any plan other than the UFCW Tri-State Health & Welfare Fund (other employment, a spouse's employer, a parent, Medicare, etc)? Check the type of benefit that the other plan will cover and the name of the other insurance company or union.									
	on: Medical/Surgery Yes 🗆 No	Major Medical ☐ Yes ☐ No		r Prescription E Yes □ No	Benefit Der ☐ Yes		Vision ☐ Yes ☐ No		
Name and Address of Other Insurance Company Is this an HMO? Yes □ No									
Section 3 - Life Insurance Beneficiary Designation									
You may name anyone you wish as beneficiary. Benefits are available if provided for in your Collective Bargaining Agreement.									
Death Benefi	Death Benefits to be paid to: Relationship								
Address:									
Social Security Number(s):									
Section 4 - Signature and Authorization to Release Information									
The Benefits available are subject to the accuracy of the information provided. I agree to be responsible to reimburse the Fund for payment made by the Fund when there are other benefits available. I also agree to the release of information from any employer, insurance company, health care provider or organization regarding coverage.									
Employee/Pa	rticipant Signature				Date_				
Section 5 - General Provisions									
 If adding a spouse, attach a copy of the marriage certificate; <u>AND</u> a copy of the front page of your latest filed federal tax return confirming this dependent as a spouse; <u>OR</u> documentation dated within the last 6 months establishing current relationship status. If dropping a spouse, the Fund needs a copy of your Divorce Decree. If adding a child, attach a copy of their birth certificate showing the full name of both parents, or a Qualified Medical Child Support Order properly issued by Family Court. 									
What is your E-mail address?									
Section 6 - Comments / Additional Information									