

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

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ENROLLMENT INFORMATION FORM - ACTIVE PARTICIPANT

Section 1 - Employee Information

This section requires information about you, the employee/participant. Please complete each area.

Employee (Participant) Last Name	First Name/Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number
Employee (Participant) Address	City / State Zip			Phone Number
Name of Employer	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> CSA	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Separated	Local Union Number / /

Section 2 - Dependent & Insurance Information

This section requires detailed information about you and your dependents, other employment and other group insurance coverage.

Yourself/ Participant	Last Name,	First Name,	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number
Name and Address of <u>other</u> Employer if applicable						
Does the person listed above have coverage available through any plan other than the UFCW 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.						
Hospitalization: Medical/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Major Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Drug Card or Prescription Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Address of Other Insurance Company						Is this an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse	Last Name,	First Name,	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number
Name and Address of Employer						
Does the person listed above have coverage available through any plan other than the UFCW 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.						
Hospitalization: Medical/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Major Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Drug Card or Prescription Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Address of Other Insurance Company						Is this an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child	Last Name,	First Name,	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number
Name and Address of Employer						
Does the person listed above have coverage available through any plan other than the UFCW 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.						
Hospitalization: Medical/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Major Medical <input type="checkbox"/> Yes <input type="checkbox"/> No		Drug Card or Prescription Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and Address of Other Insurance Company						Is this an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Continued
Enrollment Information Form**

Child	Last Name,	First Name,	Middle Initial	Sex	Date of Birth	Social Security Number
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	

Name and Address of Employer

Does the person listed above have coverage available through any plan other than the UFCW 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.

Hospitalization: Medical/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Major Medical <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Card or Prescription Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name and Address of Other Insurance Company

Is this an HMO?
 Yes No

Child	Last Name,	First Name,	Middle Initial	Sex	Date of Birth	Social Security Number
				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	

Name and Address of Employer

Does the person listed above have coverage available through any plan other than the UFCW 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.

Hospitalization: Medical/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Major Medical <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Card or Prescription Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
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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 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/Participant Signature _____ Date _____

Section 5 - General Provisions

- If adding a spouse, attach a copy of the marriage certificate; **AND** a copy of the front page of your latest filed federal tax return confirming this dependent as a spouse; **OR** 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