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

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www.tsonline.com

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	Date of Birth	Social Security Number
		□ M □ F	/ /	
Employee (Participant) Address	**City / State Zip**			**Phone Number**

Name of Employer				
	□ Full time □ Part time □ CSA	Marital Status: □Single □Married □Separated □Divorced	Local Union Number	Date of Hire / /

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	Date of Birth	Social Security Number
		□ M □ F	/ /	

Name and Address of other Employer if applicable

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.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
□Yes □ No	□Yes □ No	□Yes □ No	□Yes □ No	□Yes □ No

Name and Address of Other Insurance Company — Is this an HMO? □Yes □ No

Spouse	Last Name, First Name, Middle Initial	Sex	Date of Birth	Social Security Number
		□ M □ F	/ /	

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.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
□Yes □ No	□Yes □ No	□Yes □ No	□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	Social Security Number
		□ M □ F	/ /	

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.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
□Yes □ No	□Yes □ No	□Yes □ No	□Yes □ No	□Yes □ No

Name and Address of Other Insurance Company — Is this an HMO? □Yes □ No

Continued
Enrollment Information Form

Child	Last Name, First Name, Middle Initial	Sex □ M □ 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 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.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
□Yes □ No	□Yes □ No	□Yes □ No	□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 □ M □ 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 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.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
□Yes □ No	□Yes □ No	□Yes □ No	□Yes □ No	□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 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, heath 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