

UFCW BAY AREA AND UFCW NORTHERN CALIFORNIA HEALTH AND WELFARE TRUST FUND

Mail: P. O. Box 8086 · Walnut Creek, CA 94596-8086

Telephone: (925) 746-7530 · (800) 794-5678 · Facsimile: (925) 932-9758

INSTRUCTIONS Please also read the important information on the back of the form.

The Enrollment Form must be completed in order to enroll you and your dependents, (when eligible) for Health & Welfare coverage. Be sure to complete **all** of the information requested on the Enrollment Form.

Qualifying Hours

All Employees (except Courtesy Clerks) ---- 92 or more hours worked in each month

Courtesy Clerk Employee ----- 64 or more hours worked in each month

Qualifying Period Four months of Qualifying Hours (first two months must be consecutive). Eligibility begins the first day of the 6th month after the 4-month Qualifying Period has been satisfied.

NEW HIRE ENROLLMENT FORM

Employer: _____

Date of Hire: _____

Union Local: _____

Transfer: No Yes (Attach Transfer Form)

Prior Job Location/Local: _____

Date of Transfer: ; _____

TO ENROLL, ADD OR CHANGE COVERAGE FOR YOUR DEPENDENT, THE FOLLOWING DOCUMENTATION IS REQUIRED,

- Copy of certified Marriage Certificate required to enroll spouse or Certificate of Domestic Partnership must be submitted to add your Domestic Partner. (Eligible for spouse/domestic partner coverage after 25 months of employment.)
- Copies of certified Birth Certificates must be submitted for dependent children. (Certification of full-time student status will be required for dependent children ages 19 through 23 when coverage begins.)
- Stepchildren must live with you and be primarily dependent on you for support.
- Foster & Adopted children: Legal Guardianship or Court adoption papers are required.

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES.

Section 1 COVERAGE SELECTION

Medical Plan: PPO Medical	Dental Plan: <input type="checkbox"/> Delta Dental (Bay Area Participants) <input type="checkbox"/> Indemnity Plan (NoCA Participants)
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Section 2 PARTICIPANT/EMPLOYEE INFORMATION

Last Name	First Name	Initial	Gender	Social Security #
Mailing Address (Street or P. O. Box) <input type="checkbox"/> New		City	State	Zip Code
Telephone Number	Date of Birth (MM/DD/YY)	Current Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Date of Marriage/Divorce (MM/DD/YY)

Section 3 DEPENDENT(S) INFORMATION Dependent coverage for children only under Plan C/Standard

Last Name	First Name	Relation	Gender	Date of Birth (MM/DD/YY)	Dependent Social Security# (Required)
Spouse/Domestic Partner					
Dependent 1					
Dependent 2					
Dependent 3					
Dependent 4					

Section 4 BENEFICIARY OF DEATH BENEFIT

Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City	State	Zip Code	
Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City	State	Zip Code	
Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	%
Street Address		City	State	Zip Code	

Section 5 SPOUSE or DOMESTIC PARTNER EMPLOYMENT AND OTHER INSURANCE

Is your Spouse or Domestic Partner currently employed? Yes No If 'No', skip rest of Section 5.
If 'Yes' or if spouse has retiree coverage from former employer, please provide the following information:

Name of Spouse's or Domestic Partner's Employer:		Employer's Telephone:	
Street Address	City	State	Zip Code

Does your Spouse's or Domestic Partner's Employer provide any health insurance coverage? Yes No If 'No', skip rest of Section 5.

Please note that under Plan Rules your Spouse's or Domestic Partner's failure to obtain health insurance coverage provided by his/her Employer may result in a reduction of benefits provided by this Plan for an eligible Spouse. This applies to participants with Plan A/Premier and Plan B/Ultra

If your Spouse or Domestic Partner is enrolled in a Plan, mark the 'Yes' box and provide coverage information about the Insurance Carrier.
If your Spouse or Domestic Partner is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Enrolled in Medical/Rx Plan?	<input type="checkbox"/> Yes	Effective date: _____	Carrier: _____	Check here if HMO <input type="checkbox"/>
	<input type="checkbox"/> No	Check one of the following:		
			<input type="checkbox"/> Not offered by Employer	
			<input type="checkbox"/> Offered by Employer	Employee monthly cost: \$ _____

Enrolled in Dental Plan?	<input type="checkbox"/> Yes	Effective date: _____	Carrier: _____	
	<input type="checkbox"/> No	Check one of the following:		
			<input type="checkbox"/> Not offered by Employer	
			<input type="checkbox"/> Offered by Employer	Employee monthly cost: \$ _____

Enrolled in Vision Plan?	<input type="checkbox"/> Yes	Effective date: _____	Carrier: _____	
	<input type="checkbox"/> No	Check one of the following:		
			<input type="checkbox"/> Not offered by Employer	
			<input type="checkbox"/> Offered by Employer	Employee monthly cost: \$ _____

Next Open Enrollment Period for Spouse's Employer Month: _____ Year: _____

Section 6 OTHER INSURANCE COVERAGE FOR YOU OR ANY ENROLLED DEPENDENT CHILDREN

Are you covered by Medicare?	Is your Spouse or Domestic Partner covered by Medicare?	Any other dependent Covered by Medicare?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes Names(s) _____

Are you or any of your dependent children covered by any other Group Insurance? If so please provide us with the name of the other carrier and who is covered.

Covered Person(s)	Other Carrier(s)
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PLEASE READ THE INFORMATION BELOW AND SIGN

FRAUD NOTICE

I UNDERSTAND THAT I MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTIES FOR COMMITTING A FRAUDULENT INSURANCE ACT IF I KNOWINGLY PROVIDE ANY MATERIALLY FALSE INFORMATION TO, OR CONCEAL ANY MATERIAL FACTS FROM, THE TRUST FUND WITH THE INTENT TO DEFRAUD OR MISLEAD THE TRUST FUND.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I AUTHORIZE MY PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN LISTED ABOVE, OR THE TRUST FUND ANY AND ALL INFORMATION OR RECORDS PERTAINING TO MEDICAL HISTORY, INCLUDING SERVICES RENDERED, OR TREATMENT GIVEN TO ANYONE ENROLLED NOW OR ADDED LATER FOR THE PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM INTERNAL ADMINISTRATIVE FUNCTIONS. I UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY CONFIDENTIAL INFORMATION TO OTHERS. ANY SUCH DISCLOSURE SHALL BE MADE IN COMPLIANCE WITH ALL APPLICABLE LAWS. THE TRUST FUND, ITS AGENTS OR EMPLOYEES, SHALL USE ALL REASONABLE SAFEGUARDS TO ENSURE THAT ANY USE OR DISCLOSURE OF MY CONFIDENTIAL INFORMATION IS SOLELY FOR THE PURPOSE OF ADMINISTERING BENEFITS UNDER THE PLAN.

SPOUSE'S or DOMESTIC PARTNER'S CONSENT TO DISCLOSURE OF SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION

BY MY SIGNATURE BELOW, I AUTHORIZE THE TRUST FUND TO OBTAIN MY SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION FROM MY EMPLOYERS FOR PURPOSES OF DETERMINING MY ELIGIBILITY AS A SPOUSE UNDER THE PLAN.

SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM, WHICH I HAVE FULLY READ AND UNDERSTAND.

Participant's Signature: _____	Date: _____
Spouse's Signature: _____	Date: _____
Or	
Domestic Partner's Signature: _____	Date: _____