CHOICE PLAN 2014
Choice Benefits Enrollment Form
(NO PC)

Participant Name (please print) Social Security #

Participant Address: Street Apt. # City State Zip Code

Date of Birth | Sex: □ Male □ Female | Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Your Medical Plan Options

Each option is shown below. After reading your Enrollment Handbook check the options you want.

Check One

□ Dual Income Option A * (Waive medical for family) **You receive $200/month in Benefit Credits**	□ Dual Income Option B * (Waive medical, prescription, vision, and dental for spouse) **You receive $125/month in Benefit Credits**	□ Dual Income Option C* (waive medical for spouse) **You receive $100/month in Benefit Credits**

* Regardless of your election, you must also complete the Proof of Other Coverage Form on the reverse side of this form.

Your Choice Benefit Options

Retirement 401(k) Plan Account	
Enter the amount of benefit credits you want to contribute to the Retirement 401(k) plan in the column on the right. If you choose this option, complete and sign the separate 401(k) enrollment and beneficiary forms.	$_____/mo
Paid Time Off Bank (Taxable Income)	
Enter the amount of benefit credits you want to contribute to the Paid Time Off Bank.	$_____/mo
Extended Eligibility Bank	
Enter the amount of benefit credits you want to contribute to the Extended Eligibility Bank in the column to the right (minimum $200)	$_____/mo
Health Care Spending Account	
Enter the amount of benefit credits you want to contribute to the Health Care Spending Account. (max $500)	$_____/mo
Supplemental Life Insurance	
Choose the amount of Supplemental Life Insurance: ☐ $5,000 ☐ $10,000 Enter the amount of benefit credits needed to buy your chosen amount. See the Choice Plan Enrollment brochure for the cost of each amount.	$_____**/mo**
Total Benefit Credits	$_____**/mo**

Authorization - My signature below indicates that I have read and understood this Election Form and the descriptive materials made available to me by the UFCW Local 1776 and Participating Employers Health and Welfare Fund. I understand that these elections will remain in effect until the next annual enrollment period unless I have a qualified change in family status. I certify that the information on this form is complete and accurate to the best of my knowledge**. I understand that if this information changes in the future, I am obligated to notify the Fund Office within 30 days. Failure to do so may affect benefit coverage.**

Participant Signature Date Signed

*****Please contact the Fund Office at 1-800-458-8618 if you should have any questions*****