UFCW TRUST
Working For Your Benefit

Mail: P.O. Box 4100 Concord, CA 94524-4100
Telephone: (800) 552-2400
Facsimile: (925) 746-7549
www.ufcwtrust.com

UEBT ACTIVE
PREMIER BENEFIT LEVEL
ENROLLMENT FORM 4

INSTRUCTIONS **PLEASE READ AND COMPLETE ALL INFORMATION ON THIS FORM THAT APPLY TO YOUR HOUSEHOLD**

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

SECTION 1 PURPOSE FOR ENROLLMENT REQUEST

PLEASE CHECK ONE OF THE BOXES BELOW TO INDICATE IF THIS IS A NEW HIRE, TRANSFER OR A CHANGE ENROLLMENT REQUEST

☐ NEW HIRE
DATE OF HIRE: _____
☐ *RETURN FROM MILITARY

☐ CHANGE OF MARITAL STATUS
☐ CHANGE OF DEPENDENTS
☐ CHANGE OF CARRIER
☐ CHANGE OF NAME

☐ TRANSFER ENROLLMENT
☐ **TRANSFER FROM RECIPROCAL FUND
PRIOR JOB LOCATION/LOCAL: _____
DATE OF TRANSFER: _____

*** RETURN FROM MILITARY = ATTACH A COPY OF FORM DD-2214**

**** TRANSFER FROM RECIPROCAL FUND = IF RECIPROCAL FUND IS SOUTHERN CALIFORNIA WHOLESALE BUTCHERS, ATTACH A REQUEST FOR TRANSFER CREDITS FORM**

SECTION 2 COVERAGE SELECTION PLEASE NOTE: IF YOU MAKE A BENEFIT SELECTION THAT IS NOT CURRENTLY AVAILABLE TO YOU, YOUR REQUEST WILL BE DENIED

MEDICAL PLAN SELECTION:

☐ BLUE SHIELD PLAN (PPO) ☐ KAISER PLAN (HMO)

DENTAL PLAN SELECTION:

☐ PREMIER ACCESS
☐ LIBERTY DENTAL
☐ * DELTA DENTAL
*** Available only if you are currently enrolled in Delta Dental with UFCW Trust**

SECTION 3 MEMBER INFORMATION

Last Name	First Name	Middle Initial	Gender	Member ID # / SSN	Union Local Number

Mailing Address (Street or P.O. Box)	City	State	Zip Code

Date of Birth	Current Marital Status	Date of Marriage / Divorce / Domestic Partner Certification
	☐ Never Married ☐Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	

Cell Phone Number	Home Telephone Number	Email Address

SECTION 4 DEPENDENT INFORMATION *(For additional dependents, write on the back of this form)*

TO ADD, CHANGE OR REMOVE COVERAGE FOR DEPENDENTS PLEASE REFER TO THE ATTACHED DOCUMENTATION SPECIFICATIONS FORM

Last Name	First Name	Relationship	Gender	Date of Birth	Dependent Social Security #

SECTION 5 BENEFICIARY OF DEATH BENEFIT

Complete a Death Beneficiary Change Form for all subsequent changes *(available at www.ufcwtrust.com)* **Total % Allocated must = 100%**

No benefits will be paid if the Death Benefit claim is received by the Trust Fund office more than one year after the Member or Dependent's death

Beneficiary's Last Name	First Name	Middle Initial	Relationship	Social Security # or Tax ID #	Percentage (%) Allocated

Street Address	City	State	Zip Code

Beneficiary's Last Name	First Name	Middle Initial	Relationship	Social Security # or Tax ID #	Percentage (%) Allocated

Street Address	City	State	Zip Code

SECTION 6 MEMBER / PARTICIPANT CERTIFICATION *(Please Read and Sign Below)*

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 DE-FRAUD OR MISLEAD THE TRUST FUND.

DISCLOSURE CONFIDENTIAL INFORMATION: I UNDERSTAND THAT A PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY MAY BE REQUESTED TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN, 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 PURPOSE OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM ADMINISTRATIVE FUNCTIONS AND THAT BY PARTICIPATING IN THE PLAN I AM ALLOWING SUCH DISCLOSURES TO BE MADE. I ALSO UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY INFORMATION, OR INFORMATION FOR MY DEPENDENTS, CONFIDENTIAL INFORMATION TO OTHERS, INCLUDING TO THE BUSINESS PARTNERS, BUSINESS ASSOCIATES AND VENDORS OF THE PLAN AND/OR THE TRUST FUND IN ORDER TO PROVIDE ME AND MY DEPENDENTS, OR INFORM ME AND MY DEPENDENTS OF, ADDITIONAL BENEFITS AND OPPORTUNITIES PROVIDED BY OR MADE AVAILABLE THROUGH THE PLAN AND/OR THE TRUST FUND AND/OR THE BUSINESS PARTNERS, BUSINESS ASSOCIATES AND VENDORS OF THE PLAN AND/OR THE TRUST FUND. I ALSO UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY DISCLOSE MY CONTACT AND DEMOGRAPHIC INFORMATION TO THE UNION LOCALS AND CONTRIBUTING EMPLOYERS FOR THEIR INTERNAL ADMINISTRATIVE PURPOSES. ANY SUCH DISCLOSURES SHALL BE 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 AND/OR THE OTHER PURPOSES SET FORTH ABOVE.

ARBITRATION: I UNDERSTAND THAT ANY DISPUTE OR CONTROVERSY WHICH MAY ARISE BETWEEN MYSELF OR ANY FAMILY MEMBER AND A PREPAID PLAN OR HMO, OR ANY OF ITS PROVIDERS, SHALL BE SETTLED BY THE PREPAID PLAN'S OR HMO'S FINAL AND BINDING ARBITRATION RULES, IF ANY.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION I PROVIDED AS PART OF THIS ENROLLMENT PROCESS IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE DURING THIS ENROLLMENT PROCESS, WHICH I HAVE FULLY READ AND UNDERSTAND.

X	*Member's Signature:*	*Date:*
X	*Spouse/Domestic Partner's Signature:*	*Date:*

This form cannot be accepted if it is not signed!

For questions or concerns please contact the Health and Welfare Services department at 1-800-552-2400

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OTHER INSURANCE INFORMATION SURVEY
UEBT ACTIVE / RETIREE
FORM 6

INSTRUCTIONS Please read and complete all information as it is applicable to you and your family regarding insurance other than your UFCW Trust Fund insurance.

SECTION 1 MEMBER INFORMATION

Last Name	First Name	Middle Initial	Gender	Member ID # / SSN	Date Of Birth	Union Local

SECTION 2 ACKNOWLEDGEMENTS OF LIABILITY

INITIAL HERE ***ACTIVE OR RETIREE*** ☐	I ACKNOWLEDGE AND UNDERSTAND THAT I AM LIABLE FOR ALL CLAIMS FOR DEPENDENTS DEEMED INELIGIBLE.
INITIAL HERE ***ACTIVE OR RETIREE*** ☐	UPON REQUEST FROM THE TRUST FUND OFFICE, I AGREE TO AUTHORIZE THE TRUST FUND OFFICE TO OBTAIN SOCIAL SECURITY ADMINISTRATION (SSA) RECORDS TO CONFIRM INFORMATION ABOUT MY AND MY ENROLLED DEPENDENTS' EMPLOYMENT.
INITIAL HERE ***ACTIVE OR RETIREE*** ☐	I ACKNOWLEDGE AND UNDERSTAND THAT IF MY ENROLLED SPOUSE/DOMESTIC PARTNER HAS ACCESS TO BENEFITS THROUGH THEIR OWN OR FORMER EMPLOYMENT, MY SPOUSE/DOMESTIC PARTNER MUST ENROLL IN THE PLAN THAT IS AT LEAST AS COMPREHENSIVE AS THE UEBT ACTIVE PLAN OR MY SPOUSE/DOMESTIC PARTNER BENEFITS WILL BE REDUCED. IF MY SPOUSE/DOMESTIC PARTNER'S EMPLOYER DOES NOT OFFER MEDICAL AND/OR DENTAL COVERAGE, A LETTER FROM MY SPOUSE/DOMESTIC PARTNER'S EMPLOYER WILL BE REQUIRED VERIFYING THAT COVERAGE IS NOT AVAILABLE.
INITIAL HERE ***RETIREES ONLY*** ☐	I ACKNOWLEDGE AND UNDERSTAND THAT IF I HAVE ACCESS TO BENEFITS THROUGH MY OWN CURRENT OR FORMER EMPLOYMENT, I MUST ENROLL IN THE PLAN THAT IS AT LEAST AS COMPREHENSIVE AS THE UFCW & EMPLOYERS BENEFIT TRUST RETIREE PLAN AS SOON AS POSSIBLE OR MY BENEFITS WILL BE REDUCED. IF MY EMPLOYER DOES NOT OFFER MEDICAL OR DENTAL COVERAGE, A LETTER FROM MY EMPLOYER WILL BE REQUIRED VERIFYING THAT COVERAGE IS NOT AVAILABLE.
INITIAL HERE ***RETIREES ONLY*** ☐	I ACKNOWLEDGE AND UNDERSTAND THAT IF ANY OF MY ENROLLED DEPENDENT CHILDREN HAVE ACCESS TO BENEFITS THROUGH THEIR OWN CURRENT EMPLOYMENT, THAT DEPENDENT CHILD MUST ENROLL IN THEIR CURRENT EMPLOYER'S PLAN OR THEIR BENEFITS WILL BE REDUCED. IF MY DEPENDENT CHILD'S EMPLOYER DOES NOT OFFER MEDICAL OR DENTAL COVERAGE, A LETTER FROM MY DEPENDENT CHILD'S EMPLOYER WILL BE REQUIRED VERIFYING THAT COVERAGE IS NOT AVAILABLE.

SECTION 3 OTHER INSURANCE SURVEY FOR MEMBER & DEPENDENTS

QUESTIONS	ANSWERS	
1. Are you or any of your dependents receiving Social Security Disability Insurance (SSDI)?	**YES** ☐	**NO** ☐
a. If yes, which member/dependent(s) have been awarded Social Security Disability Insurance (SSDI), and what is their Award effective date?	Name: _____ Effective: _____ Name: _____ Effective: _____	
2. Are you or any of your dependents eligible for Medicare? *(if yes, complete questions a and b, below)*	**YES** ☐	**NO** ☐
a. Are you or any of your dependents enrolled in Medicare Part A, B, C, or D?	**YES** ☐	**NO** ☐
b. Which Member/Dependent(s) are enrolled in Medicare Part A, B, C, or D? *Note: If you enroll in a Medicare Part D prescription drug plan, your prescription drug coverage will be terminated under the Trust Fund on the date that your Part D Plan becomes effective. You will only have the individual Part D prescription drug plan which you purchased.*	Name: _____ Name: _____	
3. Is your Spouse/Domestic Partner currently employed? *(if yes, complete questions a, b, and c, below)*	**YES** ☐	**NO** ☐
a. What is the name of your Spouse/Domestic Partner's employer?	Name: _____	
b. Is Medical coverage offered by your Spouse/Domestic Partner's employer?	**YES** ☐	**NO** ☐
c. Is your Spouse/Domestic Partner enrolled in their employer's Medical Plan?	**YES** ☐	**NO** ☐
4. Are you or any of your dependents enrolled in any OTHER group Medical Insurance?	**YES** ☐	**NO** ☐

5. Please fill out the Medical Carrier information for each member/dependent covered by any other group Medical Insurance(s).
(Helpful hint: Refer to your carrier ID card to help answer this portion. For additional dependents, attach a signed and dated sheet of paper listing the required information.)

Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):	Medical Carrier Name:	Carrier Type:	Plan Type:
	1		☐ **PPO**	☐ **ACTIVE PLAN**
	2		☐ **HMO**	☐ **RETIREE PLAN**
Subscriber Relationship to Member	3		☐ **EPO**	
	4		☐ **POS**	
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):	Medical Carrier Name:	Carrier Type:	Plan Type:
	1		☐ **PPO**	☐ **ACTIVE PLAN**
	2		☐ **HMO**	☐ **RETIREE PLAN**
Subscriber Relationship to Member	3		☐ **EPO**	
	4		☐ **POS**	
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):	Medical Carrier Name:	Carrier Type:	Plan Type:
	1		☐ **PPO**	☐ **ACTIVE PLAN**
	2		☐ **HMO**	☐ **RETIREE PLAN**
Subscriber Relationship to Member	3		☐ **EPO**	
	4		☐ **POS**	

SECTION 3 OTHER INSURANCE SURVEY FOR MEMBER & DEPENDENTS

6. Are you or any of your dependents enrolled in any OTHER group Dental Insurance? **YES** ☐ **NO** ☐

7. Please fill out the Dental Carrier information for each member/dependent covered by any other group Dental Insurance(s).

(Helpful hint: Refer to your carrier ID card to help answer this portion. For additional dependents, attach a signed and dated sheet of paper listing the required information.)

Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Dental Carrier Name:	Carrier Type:		Plan Type:	
	1			☐	DMO	☐	ACTIVE PLAN
	2			☐	INDEMNITY	☐	RETIREE PLAN
Subscriber Relationship to Member	3						
	4						
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Dental Carrier Name:	Carrier Type:		Plan Type:	
	1			☐	DMO	☐	ACTIVE PLAN
	2			☐	INDEMNITY	☐	RETIREE PLAN
Subscriber Relationship to Member	3						
	4						
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Dental Carrier Name:	Carrier Type:		Plan Type:	
	1			☐	DMO	☐	ACTIVE PLAN
	2			☐	INDEMNITY	☐	RETIREE PLAN
Subscriber Relationship to Member	3						
	4						

8. Are you or any of your dependents enrolled in any OTHER group Prescription (RX) Coverage? **YES** ☐ **NO** ☐

9. Please fill out the Prescription Carrier information for each member/dependent covered by any other group Prescription (RX) Coverage.

(Helpful hint: Refer to your carrier ID card to help answer this portion. For additional dependents, attach a signed and dated sheet of paper listing the required information.

Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Prescription Carrier Name:
	1		
	2		
Subscriber Relationship to Member	3		
	4		
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Prescription Carrier Name:
	1		
	2		
Subscriber Relationship to Member	3		
	4		
Subscriber First and Last Name	Subscriber covering whom (List First/Last Name):		Prescription Carrier Name:
	1		
	2		
Subscriber Relationship to Member	3		
	4		

SECTION 4 MEMBER / PARTICIPANT CERTIFICATION *(Please Read and Sign Below)*

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ARBITRATION: I UNDERSTAND THAT ANY DISPUTE OR CONTROVERSY WHICH MAY ARISE BETWEEN MYSELF OR ANY FAMILY MEMBER AND A PREPAID PLAN OR HMO, OR ANY OF ITS PROVIDERS, SHALL BE SETTLED BY THE PREPAID PLAN'S OR HMO'S FINAL AND BINDING ARBITRATION RULES, IF ANY.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION I PROVIDED AS PART OF THIS ENROLLMENT PROCESS IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE DURING THIS ENROLLMENT PROCESS, WHICH I HAVE FULLY READ AND UNDERSTAND.

X	*Member's Signature:*	*Date:*
X	*Spouse/Domestic Partner's Signature:*	*Date:*

This form cannot be accepted if it is not signed!

For questions or concerns please contact the Health and Welfare Services department at 1-800-552-2400

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UFCW & EMPLOYERS BENEFIT TRUST
AUTHORIZATION FOR PAYROLL DEDUCTION FOR EMPLOYEE PREMIUM CONTRIBUTION

NAME _____LAST 4 DIGITS OF **SOCIAL SECURITY NO.**_____
(PLEASE PRINT)

I hereby request the Trust Fund Office establish coverage for my dependents and/or Spouse/Domestic Partner under the UFCW & Employers Benefit Trust Fund in accordance with the elections I made during the enrollment process.

I authorize my employer to withhold the required weekly premium amount from my paycheck and to remit the payment directly to the UFCW & Employers Benefit Trust Fund. I understand that if my Employer cannot deduct this amount from my paycheck, I will be billed for the weekly premium amount, and that it is my responsibility to make timely payments to the UFCW & Employers Benefit Trust Fund by the due date indicated on the bill, or risk losing my coverage.

I understand that, in order to establish coverage for my dependent(s), I must continue to satisfy the Plan's eligibility rules, including the hours requirements for continued coverage, and I must pay the required weekly premium amount in advance of the month of coverage.

Please check the appropriate box(es) below based on your current Plan level and the elections made during the enrollment process:

Level of Coverage	Weekly Rates			
Premier Plan – PPO				
Health Care Partnership	☐ Employee	$0 *(I only want coverage for myself)*		
	☐ Spouse/Domestic Partner	$20	☐ 1 Child	$10
	☐ 2 Children	$20	☐ 3 Children or more	$30
Personal Direction	☐ Employee	$0 *(I only want coverage for myself)*		
	☐ Spouse/Domestic Partner	$30	☐ 1 Child	$15
	☐ 2 Children	$30	☐ 3 Children or more	$45
Premier Plan - Kaiser				
Health Care Partnership	☐ Employee	$0 *(I only want coverage for myself)*		
	☐ Spouse/Domestic Partner	$20	☐ 1 Child	$10
	☐ 2 Children	$20	☐ 3 Children or more	$30
Personal Direction	☐ Employee	$0 *(I only want coverage for myself)*		
	☐ Spouse/Domestic Partner	$30	☐ 1 Child	$15
	☐ 2 Children	$30	☐ 3 Children or more	$45

TOTAL WEEKLY PREMIUM AMOUNT AUTHORIZED (PLEASE USE CHART ABOVE TO CALCULATE): $_____

SIGNATURE: _____ DATE: _____

Please mail this completed and signed form to the Trust Fund address above, Attn: Eligibility –A within 10 days of receipt.

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DOCUMENTATION SPECIFICATIONS
UEBT ACTIVE / RETIREE
FORM 7

INSTRUCTIONS **TO ADD, CHANGE, OR REMOVE COVERAGE FOR DEPENDENTS, A COPY OF THE FOLLOWING DOCUMENTATION IS REQUIRED**

TO ADD A DEPENDENT

SPOUSE:	• A COUNTY-CERTIFIED MARRIAGE CERTIFICATE **PLUS ANY ONE OF THE FOLLOWING:** • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN WITH YOUR SPOUSE LISTED OR ACKNOWLEDGMENT OF YOUR TAX EXTENSION (FORM 4868) (PLEASE COVER UP FINANCIAL INFORMATION) • RECENT (WITHIN 60 DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR SPOUSE'S NAME AT YOUR ADDRESS
DOMESTIC PARTNER:	• CERTIFICATE OF REGISTRATION OF DOMESTIC PARTNERSHIP (CRDP) ISSUED BY THE CALIFORNIA SECRETARY OF STATE **PLUS:** • RECENT (WITHIN 60 DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR DOMESTIC PARTNER'S NAME AT YOUR ADDRESS
NATURAL CHILD:	• COUNTY-ISSUED CERTIFIED BIRTH CERTIFICATE
STEPCHILD:	• COUNTY-ISSUED CERTIFIED BIRTH CERTIFICATE **PLUS:** • COUNTY-CERTIFIED MARRIAGE CERTIFICATE WITH NATURAL PARENT
ADOPTED CHILD:	• COURT ADOPTION PAPERS
FOSTER CHILD:	• FOSTER HOME LICENSE **PLUS:** • LEGAL GUARDIANSHIP PAPERS FOR THE CHILD
DISABLED DEPENDENT:	• DISABLED OVERAGE DEPENDENT CHILD FORM *GO TO WWW.UFCWTRUST.COM TO DOWNLOAD THE FORM OR CALL 1-800-552-2400* • PROOF OF CURRENT SOCIAL SECURITY DISABILITY AWARD LETTER • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN **PLUS:** • ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE FOLLOWING CATEGORIES TO WHICH THIS CHILD BELONGS: NATURAL CHILD, STEP CHILD, ADOPTED CHILD, OR FOSTER CHILD
CHILD OF A RETIREE: (Age 19-23)	IN ADDITION TO THE ABOVE REQUIREMENTS, A CHILD OF A RETIREE WHO IS AGE 19 THROUGH 23 MUST SUBMIT: • UEBT RETIREE HEALTH PLAN STUDENT CERTIFICATION FORM *GO TO WWW.UFCWTRUST.COM TO DOWNLOAD THE FORM OR CALL 1-800-552-2400*

WHEN ADDING A DEPENDENT PLEASE ATTACH A COMPLETED OTHER INSURANCE INFORMATION SURVEY AND AN AUTHORIZATION TO DEDUCT FORM

TO REMOVE A DEPENDENT

DIVORCE OF SPOUSE:	• FINAL DIVORCE DECREE ENTERED WITH THE COURT
DISSOLUTION OF DOMESTIC PARTNERSHIP:	• FINAL JUDGMENT OF DISSOLUTION OR TERMINATION OF DOMESTIC PARTNERSHIP PAPERWORK
DEPENDENT DEATH:	• CERTIFIED DEATH CERTIFICATE

PLEASE MAIL YOUR DOCUMENTS TO:

UFCW & EMPLOYERS TRUST, LLC
P.O. BOX 4100
Concord, CA 94524-4100