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

# OTHER INSURANCE INFORMATION SURVEY
# SPOUSE/DOMESTIC PARTNER

**INSTRUCTIONS** Please read and complete all information as it is applicable to your Spouse/Domestic Partner regarding insurance other than your UFCW Trust Fund insurance.

**SECTION 1** **MEMBER/PARTICIPANT INFORMATION** **SPOUSE/DOMESTIC PARTNER (DP) INFORMATION**

| Last Name | | First Name | Middle Initial | Gender | Member ID # / SSN | Date Of Birth | Union Local |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Spouse/DP Last Name | | Spouse/DP First Name | Middle Initial | Gender | Spouse/DP ID#/SSN | Date of Birth | |
| | | | | | | | |

**SECTION 2** **MEMBER/PARTICIPANT 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** **SPOUSE/DOMESTIC PARTNER OTHER INSURANCE SURVEY**

| QUESTIONS | ANSWERS | |
|---|---|---|
| 1. Does your Spouse/Domestic Partner receive a Social Security Disability Insurance (SSDI)? | YES ☐ | NO ☐ |
| a. If yes, what is their Award effective date? | Effective Date: ______________________________ | |
| 2. Is your Spouse/Domestic Partner eligible for Medicare? *(if yes, complete question a below)* | YES ☐ | NO ☐ |
| a. Is your Spouse/Domestic Partner enrolled in Medicare Part A, B, C, or D? | YES ☐ | NO ☐ |
| 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. Is your Spouse/Domestic Partner enrolled in any OTHER group Medical Insurance? | YES ☐ | NO ☐ |
| 5. What date was your Spouse/Domestic Partner first covered under their current Medical Insurance Plan? | Effective Date: ______________________________ | |

6. Please fill out the Medical Carrier information for your Spouse/Domestic Partner's other group Medical Insurance(s).
**(Helpful hint: Refer to your carrier ID card to help answer this portion)**

| 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 | | MEDI-CAL |
| | 4 | | | | POS | | HEALTH INSURANCE MARKETPLACE |
| 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 | | MEDI-CAL |
| | 4 | | | | POS | | HEALTH INSURANCE MARKETPLACE |
| 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 | | MEDI-CAL |
| | 4 | | | | POS | | HEALTH INSURANCE MARKETPLACE |

## SECTION 3 SPOUSE/DOMESTIC PARTNER OTHER INSURANCE SURVEY

| | | |
|---|---|---|
| 7. Is your Spouse/Domestic Partner enrolled in any OTHER group Dental Insurance? | YES ☐ | NO ☐ |
| 8. What date was your Spouse/Domestic Partner first covered under their current Dental Insurance Plan? | Effective Date: ___________________________ | |

9. Please fill out the Dental Carrier information for your Spouse/Domestic Partner's other group Dental Insurance(s).
**(Helpful hint: Refer to your carrier ID card to help answer this portion)**

| 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 | | | |

| | | |
|---|---|---|
| 10. Is your Spouse/Domestic Partner enrolled in any OTHER group Prescription (RX) Coverage? | YES ☐ | NO ☐ |

11. What date was your Spouse/Domestic Partner first covered under their current Prescription (RX) Insurance Plan?

12. Please fill out the Prescription Carrier information for your Spouse/Domestic Partner's other group Prescription (RX) Coverage.
**(Helpful hint: Refer to your carrier ID card to help answer this portion)**

| 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 SPOUSE/DOMESTIC PARTNER 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*