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

UCBT ACTIVE STANDARD CLERK HELPERS ENROLLMENT FORM 1

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: _____
- ☐ ANNUAL VERIFICATION (**MEMBER ONLY**)
- ☐ ***RETURN FROM MILITARY**
- ☐ CHANGE OF MARITAL STATUS
- ☐ CHANGE OF NAME
- ☐ CHANGE OF DEPENDENTS
- ☐ 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:	DENTAL PLAN SELECTION:
☐ BLUE SHIELD INDEMNITY PLAN (PPO)	☐ PREMIER ACCESS

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 CHILD INFORMATION *(For additional dependents, write on the back of this form)*

TO ADD, CHANGE OR REMOVE COVERAGE FOR DEPENDENT CHILDREN, 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 Percentage 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 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:*

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

H:\Open Enrollment - UCBT\2018

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DOCUMENTATION SPECIFICATIONS
UCBT ACTIVE
FORM 7

INSTRUCTIONS — **TO ADD, CHANGE, OR REMOVE COVERAGE FOR DEPENDENTS, A COPY OF THE FOLLOWING DOCUMENTATION IS REQUIRED (PLEASE NOTE ORIGINAL DOCUMENTS WILL NOT BE RETURNED.)**

TO ADD A DEPENDENT

	DOCUMENTATION REQUIREMENT	TIMELINE REQUIREMENT
SPOUSE:	• COUNTY ISSUED MARRIAGE CERTIFICATE **AND 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	**SPOUSE OR DOMESTIC PARTNER** • **STANDARD MEMBER** = DOCUMENTATION MUST BE SUBMITTED WITHIN **31** DAYS OF QUALIFYING EVENT • **ULTRA MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT • **PREMIER MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT (**60** DAYS FOR HMO ENROLLMENT)
DOMESTIC PARTNER:	• CERTIFICATE OF REGISTRATION OF DOMESTIC PARTNERSHIP **AND:** • RECENT (WITHIN **60** DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR DOMESTIC PARTNER'S NAME AT YOUR ADDRESS	
NEWBORN CHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE ***NOTE:*** *If you do not have the County Issued Birth Certificate by stated deadlines, submit the Hospital Issued Birth Certificate and proof that you applied for your child's County Birth Certificate within* ***60*** *days of the date of birth (for both PPO or HMO) for six months of temporary coverage beginning at date of birth. The County Issued Birth Certificate must be received by the Trust Fund Office no later than 6 months after the date of birth.*	**NEWBORN CHILD** • **STANDARD/ULTRA MEMBER** = WITHIN **90** DAYS OF DATE OF BIRTH • **PREMIER MEMBER** = WITHIN **90** DAYS OF DATE OF BIRTH (**60** DAYS FOR HMO ENROLLMENT)
NATURAL CHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE	**CHILD DEPENDENT** • **STANDARD/ULTRA MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT OR DATE OF PLACEMENT (FOSTER/ADOPTION) • **PREMIER MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT (**60** DAYS FOR HMO ENROLLMENT) OR DATE OF PLACEMENT (FOSTER/ADOPTION)
STEPCHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE **PLUS:** • COUNTY-ISSUED MARRIAGE CERTIFICATE WITH NATURAL PARENT	
ADOPTED CHILD:	• COURT ADOPTION PAPERS	
FOSTER CHILD:	• FOSTER HOME LICENSE **PLUS:** • LEGAL GUARDIANSHIP PAPERS FOR THE CHILD	
OVERAGE DISABLED DEPENDENT: *(Must be renewed annually)*	• DISABLED OVERAGE DEPENDENT CHILD FORM • PROOF OF CURRENT SOCIAL SECURITY DISABILITY AWARD LETTER • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN SHOWING CHILD LISTED **PLUS:** • ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS CHILD BELONGS: NEWBORN CHILD, NATURAL CHILD, STEPCHILD, ADOPTED CHILD, OR FOSTER CHILD	

TO ADD A DEPENDENT BECAUSE OF CURRENT LOSS OF COVERAGE

ANY DEPENDENT TYPE:	• ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS DEPENDENT BELONGS: SPOUSE, DOMESTIC PARTNER, NEWBORN, NATURAL CHILD, STEPCHILD, ADOPTED CHILD, FOSTER CHILD OR OVERAGE DISABLED DEPENDENT CHILD **PLUS:** • A HIPAA CERT **OR** A COBRA NOTICE TO PROVE LOSS OF COVERAGE	**ANY DEPENDENT TYPE** • **LOSS OF COVERAGE** = WITHIN 30 DAYS FROM LOSS OF COVERAGE

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