UFCWTRUST
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 BENEFIT LEVEL ENROLLMENT FORM 2

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 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:	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 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

A SPOUSE/DOMESTIC PARTNER MAY ONLY BE ADDED TO COVERAGE WHEN A STANDARD MEMBER HAS MET 1200 QUALIFYING WORKED HOURS

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
UCBT 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	Union Local Number

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 UCBT 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

H:\Open Enrollment - UCBT\2018

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UFCW COMPREHENSIVE BENEFITS 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 the dependents I am enrolling under the UFCW Comprehensive Benefits Trust Fund, as listed below.

I authorize my employer to withhold the required weekly premium amount from my paycheck and to remit the payment directly to the UFCW Comprehensive Benefits Trust Fund. If I graduate into a higher benefit level and my dependent premium rates are reduced as a result of my graduation, I expressly authorize my Employer to withhold the required premium amount for coverage of my enrolled dependents related to my new benefit level. I understand that if my Employer cannot deduct the required premium amount from my paycheck, the Trust Fund Office will bill me for the required premium amount, and that it is my responsibility to make timely payments to the UFCW Comprehensive Benefits Trust Fund by the applicable due date, or coverage of my dependents may be suspended.

I understand that if my employer maintains a "cafeteria plan" under Internal Revenue Code Section 125, the required premium amounts will be withheld on a pre-tax basis, unless I affirmatively elect to decline coverage. I expressly authorize these required premium amounts to be withheld on a pre-tax basis and I understand that my authorization will stay in effect for future years if no election changes are made and the premium amounts remain the same. I also understand that I cannot change my coverage election during the plan year unless I experience a change in status event which would permit such a change under the Plan (regardless of whether or not the required premium amounts are withheld on a pre-tax basis). In addition, if these required premium amounts are withheld on a pre-tax basis, I understand that I also cannot change my election unless the change is also permitted under the applicable cafeteria plan rules.

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 dependent coverage, and I must pay the required premium amount for the month in advance of the month of coverage.

Please check the appropriate box(es) below and fill in the total, sign and date this form, and return with other enrollment forms.

Level of Coverage	Weekly Rates			
Standard Plan				
	☐ Employee	$0 *(I only want coverage for myself)*		
	☐ 1 Child	$20		
	☐ 2 Children	$40	☐ 3 Children or more	$60

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

SIGNATURE: ____ DATE: __________________

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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	<u>SPOUSE OR DOMESTIC PARTNER</u> • **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.*	<u>NEWBORN CHILD</u> • **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	<u>CHILD DEPENDENT</u> • **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	<u>ANY DEPENDENT TYPE</u> • **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