UFCW NORTHERN CALIFORNIA AND DRUG EMPLOYERS HEALTH AND WELFARE TRUST FUND
Mail: P.O. Box 4100 ■ Concord, CA 94524-4100
Telephone: (800) 552-2400 Facsimile: (925) 746-7549

ACTIVE - Enrollment Form

Instructions — **Please read and complete all information contained on this Form**

The Enrollment Form must be completed in order to enroll you and your Dependents, if applicable, for Health & Welfare coverage. Be sure to complete **ALL** of the information requested on this Enrollment Form.

Please read your Summary Plan Description for descriptions of the various plans. Remember, once an election is made you will not be permitted to change your carrier until the next annual Open Enrollment period each year (changes effective January 1). Please refer to your Summary Plan Description Handbook for special enrollment rights outside of Open Enrollment.

Please check one of the boxes below to indicate if this is a new enrollment or a change request:

- ☐ NEW ENROLLMENT
- ☐ CHANGE OF NAME
- ☐ CHANGE OF MARITAL STATUS
- ☐ CHANGE OF CARRIER
- ☐ CHANGE OF DEPENDENTS

TO ADD OR CHANGE COVERAGE FOR DEPENDENTS, THE FOLLOWING DOCUMENTATION IS REQUIRED

Dependent	Documentation
Spouse	Copy of the county-certified Marriage Certificate, PLUS any ONE of the following: (a) Page 1 of your most recently filed Federal Tax Return, (b) Acknowledgment of your tax extension (Form 4868) (please cover up financial information), (c) Recent (within 60 days) recurring household bill or account statement listing your Spouse's name at your address.
Domestic Partnership	Copy of the 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.
Divorce	Copy of your Divorce Decree
Natural Child	Copy of the county-issued Certified Birth Certificate and Dependent Certification form
Stepchild	Copy of the county-issued Certified Birth Certificate
Foster child	Legal Guardianship papers for the child, plus proof of Foster home licensure
Adopted Child	Court Adoption Papers
Disabled Dependent Child	A completed Disabled Overage Dependent Child Form, a copy of Page 1 of your most recently filed Federal Tax Return, Social Security Disability Award PLUS any ONE of the following: (a) Copy of the county-issued Certified Birth Certificate, (b) Court Adoption Papers

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 COVERAGE SELECTION

If you choose to enroll your Spouse/Domestic Partner, they will be covered under the same option you elect for yourself.

Medical Plan: (Vision Coverage is included in your medical benefits) -

I Select:

- ☐ Blue Shield Indemnity Plan (PPO)
- ☐ Kaiser (HMO) (**Must have 48 months of eligibility for HMO Coverage**)

If you select Kaiser coverage and are not eligible for Kaiser coverage your request will be denied.

Dental Plan:
I select:
☒ **Premier Access**
Please note: The Premier Access Plan is the only Dental Plan available to you.

Section 2 PARTICIPANT / EMPLOYEE INFORMATION

Last Name	First Name	Initial	Gender	**Social Security # (Required)**	Union Local
				_ _ _ - _ _ - _ _ _ _	

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

Date of Birth	Current Marital Status	Date of Marriage/Divorce/Dom.Partner Certification
	☐Divorced ☐Widowed ☐Domestic Partner ☐Single ☐Married	

Cell Phone Number	Home Telephone Number	E-mail Address

Section 3 DEPENDENT INFORMATION (to be completed only if you are electing Employee Premium contributions for dependent)

Last Name	First Name	Relation	Gender	Date of Birth	Dependent Social Security # (**Required**)
Spouse/Domestic Partner					_ _ _ - _ _ - _ _ _ _
Child 1					_ _ _ - _ _ - _ _ _ _
Child 2					_ _ _ - _ _ - _ _ _ _
Child 3					_ _ _ - _ _ - _ _ _ _

Section 4	BENEFICIARY OF DEATH BENEFIT Death Beneficiary change form must be completed for subsequent changes.				
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.					***Total of %'s must equal 100%***
Beneficiary's Last Name	First Name	MI	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code
Beneficiary's Last Name	First Name	MI	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code
Beneficiary's Last Name	First Name	MI	Relationship	Social Security # or Tax ID #	%
Street Address		City		State	Zip Code

Section 5	PARTICIPANT & 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 defraud or mislead the Trust Fund.

DISCLOSURE OF 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, or 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 you and your dependents, or inform you and your 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.

I understand that I am liable for any amounts paid by the Plan on behalf of myself, my spouse, domestic partner, or dependent child, that should not have been paid (for example, if the individual is not eligible for coverage under the plan, or if the individual has access to other group health coverage and does not enroll in that other coverage).

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 Spouse/Domestic Partner's employment.

SIGNATURE REQUIRED: *I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM, WHICH I HAVE FULLY READ AND UNDERSTAND.*

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

This Form is not acceptable if it is not signed!

For questions please contact Health and Welfare Services at 800-552-2400