UFCW & Employers Trust, LLC
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Section 1 INSTRUCTIONS

PLEASE CHECK A BOX FOR THE CLAIMS YEAR YOU ARE UPDATING INFORMATION FOR:

☐ 2008
☐ 2009
☐ 2010

[Nor Cal & Bay 25 Participants Only] 2008, 2009, 2010 Dependent Documentation Requirements: If the participant has any dependent children who are over the age of 19, be sure to attach a Student Certification Form. (Obtain a Student Certification Form from the Trust Fund your Union Local. You can also download the form at www.ufcwtrust.com).

☐ 2011

[Nor Cal and Bay 25 Participants Only] 2011 Dependent Documentation Requirements: If the participant has any dependent children who are between the age of 18 and 25, be sure to attach a Dependent Certification Form. (Obtain a Dependent Certification Form from the Trust Fund your Union Local. You can also download the form at www.ufcwtrust.com).

Section 2: List information pertaining to the participant.

Section 3: List the participant's covered Dependents. This includes a Spouse/Domestic Partner. If the participant has any dependent children who are over the age of 19, be sure to attach a Student Certification Form. (Obtain a Student Certification Form from the Trust Fund your Union Local. You can also download the form at www.ufcwtrust.com).

Section 4: This section does not apply to Retirees

Section 5: Answer every applicable question related to the current insurance information for the participant's Spouse or Domestic Partner. Please note that Spouses and Domestic Partners of participants must obtain health insurance if provided by their employer. Failure to do so may result in a reduction of benefits provided by the plan.

Section 6: Provide the Trust Fund with information regarding other insurance for you and any other family members.

Section 7: Sign and date the Annual Verification Form. Please note that, if applicable, your Spouse/Domestic Partner must sign and date the form as well.

Section 2 PARTICIPANT INFORMATION

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

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

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(S) INFORMATION

Last Name	First Name	Relation	Gender	Date of Birth	**Dependent Social Security # (Required)**
Spouse/Domestic Partner ☐ Delete Reason:					_ _ _ - _ _ - _ _ _ _

Dependent child *(Nor Cal & Bay 25 Participants Only)*

Complete a Dependent Certification Form (available at www.ufcwtrust.com) if any of the dependent children listed on this form are ages 18 through 25.

Dependent 1 ☐ Delete Reason:				_ _ _ - _ _ - _ _ _ _
Dependent 2 ☐ Delete Reason:				_ _ _ - _ _ - _ _ _ _
Dependent 3 ☐ Delete Reason:				_ _ _ - _ _ - _ _ _ _

Section 4 BENEFICIARY OF DEATH BENEFIT - This section does not apply to Retirees

Participants with the Death Benefit Extension will automatically be provided an opportunity to review Beneficiary Information with their Annual Disability Certification

COMPLETION OF ADDITIONAL SECTIONS AND SIGNATURE(S) REQUIRED ON OTHER SIDE

Section 5 SPOUSE/DOMESTIC PARTNER EMPLOYMENT AND OTHER INSURANCE — MUST BE COMPLETED EVERY YEAR

Please note that under Plan rules your Spouse/Domestic Partner's failure to obtain health insurance coverage provided by his/her Employer may result in a reduction of benefits provided by this Plan. If your Spouse/Domestic Partner is retired, and receives Retiree coverage from his/her employer, that coverage should be listed in Section 6.

5-A

Is your Spouse/Domestic Partner Currently employed? ☐ Yes ☐ No ☐ N/A — If 'No or N/A', skip the rest of Section 5, and go to Section 6. If 'Yes', please complete all of this section.

Name of Spouse/Domestic Partner's Employer: Employer's Telephone:

Street Address of Employer	City	State	Zip Code

Does your Spouse/Domestic Partner's Employer provide any health insurance coverage or funds which can be used for insurance coverage? ☐ Yes ☐ No — If 'No' skip the rest of Section 5.

*5B-5D: If your Spouse/Domestic Partner **IS** enrolled in a Plan, mark the 'Yes' box and provide information about the Insurance Carrier. If your Spouse/Domestic Partner **IS NOT** enrolled in a Plan, mark the 'No' box and check the applicable box which follows.*

5-B

Spouse/Domestic Partner Enrolled in a *Medical / Rx Plan*?

☐ Yes Effective Date: — *Carrier Name:* — Check the plan type here: Plan Covers: ☐ Employee only ☐ Employee and Family — HMO ☐ PPO ☐

☐ No **Check one of the following:** ☐ Not offered by Employer ☐ Offered by Employer — Employee monthly cost: $ _____

5-C

Spouse/Domestic Partner Enrolled in a *Dental Plan*?

☐ Yes Effective Date: — *Carrier Name:* — Check the plan type here: Plan Covers: ☐ Employee only ☐ Employee and Family — DMO ☐ PPO ☐

☐ No **Check one of the following:** ☐ Not offered by Employer ☐ Offered by Employer — Employee monthly cost: $ _____

5-D

Spouse/Domestic Partner Enrolled in a *Vision Plan*?

☐ Yes Effective Date: — *Carrier Name:* — Plan Covers: ☐ Employee only ☐ Employee and Family

☐ No **Check one of the following:** ☐ Not offered by Employer ☐ Offered by Employer — Employee monthly cost: $ _____

Next Open Enrollment period for Spouse/Domestic Partner's Employer **Month:** **Year:**

Section 6 OTHER INSURANCE COVERAGE FOR YOU OR YOUR DEPENDENT(S)

List any other insurance coverage you may have for you and your enrolled Spouse/Domestic Partner and enrolled Dependent Children.

*It is **VERY IMPORTANT** that you and your spouse/domestic partner (when eligible) enroll in Medicare Parts A and B. If you choose not to enroll, benefits will be reduced by estimated Medicare Benefits (usually 80% reduction) while covered under the PPO Plan. To be eligible for HMO coverage you are required to enroll in Medicare Parts A and B when eligible.*

6-A

Are you eligible for Medicare?:	Is your Spouse/Domestic Partner eligible for Medicare?	Are any of your Dependent Children eligible for Medicare?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No Child Name _____
If eligible, what is the reason for eligibility?	If eligible, what is the reason for eligibility?	If eligible, what is the reason for eligibility?
☐ Age (over 65) ☐ Renal Disease (ESRD)	☐ Age (over 65) ☐ Renal Disease (ESRD)	☐ Age (over 65) ☐ Renal Disease (ESRD)
☐ Disability or Railroad Retirement Board Disability	☐ Disability or Railroad Retirement Board Disability	☐ Disability or Railroad Retirement Board Disability
Are you enrolled in Medicare?:	Is your Spouse/Domestic Partner enrolled in Medicare?	Is the above Dependent Child enrolled in Medicare?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Part A Effective Date: _____	☐ Part A Effective Date: _____	☐ Part A Effective Date: _____
☐ Part B Effective Date: _____	☐ Part B Effective Date: _____	☐ Part B Effective Date: _____

6-B

Are you receiving SSDI?:	Is your Spouse/Domestic Partner receiving SSDI?:	Are any of your Dependent Children receiving SSDI?:
☐ No ☐ Yes --- *If Yes, indicate award date:*	☐ No ☐ Yes --- *If Yes, indicate award date:*	☐ No ☐ Yes --- *If Yes, indicate award date:*
Award Date: ____/____/____ (mm/dd/yyyy)	Award Date: ____/____/____ (mm/dd/yyyy)	Award Date: ____/____/____ (mm/dd/yyyy) Name:_____

6-C

Are you or and of your Dependents covered by any other Group Insurance? ☐ No ☐ Yes

If 'No', skip the rest of Section 6

Subscriber Name:

Effective Date: — Plan type: Active ☐ Retiree ☐

Name of Insurance Carrier: — Coverage type: HMO ☐ PPO ☐

Covered Person's Name(s): 1) _____ 2) _____ 3) 4)

Section 7 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.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION: I AUTHORIZE MY PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN LISTED ABOVE, 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 PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM INTERNAL ADMINISTRATIVE FUNCTIONS. I UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY CONFIDENTIAL INFORMATION TO OTHERS. ANY SUCH DISCLOSURE SHALL BE MADE 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.

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

SPOUSE/DOMESTIC PARTNER'S CONSENT TO DISCLOSURE OF SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION: BY MY SIGNATURE BELOW, I AUTHORIZE THE TRUST FUND TO OBTAIN MY SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION FROM MY EMPLOYER FOR THE PURPOSE OF DETERMINING THE LEVEL OF MY BENEFITS AS A DEPENDENT UNDER THE PLAN.

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 call Member Services at 1-800-552-2400