UFCW NORTHERN CALIFORNIA AND DRUG EMPLOYERS HEALTH & WELFARE TRUST FUND

AUTHORIZATION FOR PAYROLL DEDUCTION

THIS FORM MUST BE COMPLETED AND RETURNED TO THE TRUST FUND OFFICE TO AUTHORIZE YOUR EMPLOYER TO DEDUCT YOUR EMPLOYEE CONTRIBUTION FOR DEPENDENT COVERAGE FROM YOUR PAYCHECK

I hereby request the Trust Fund Office to establish coverage for **dependents listed below** under the UFCW Northern California and Drug Employers Health and Welfare Trust Fund. I understand that by not including a specific dependent, that dependent(s) will not be eligible to be considered for enrollment for benefit coverage under the Fund until the next Open Enrollment period or under a special enrollment right.

Please indicate the coverage you want:

☐ Member only ☐ Member +1 ☐ Member + Family

You must complete the information below and "√" the appropriate box

Dependent Name (First and Last Name)	**Social Security #**	**Date of Birth**
Name:		
Name:		
Name:		
Name:		
Name:		
Name:		

Authorization for Payroll Deduction for Employee Premium Contribution

I authorize my Employer to withhold the required monthly amount from my paycheck and to remit the payment directly to the UFCW Northern California and Drug Employers Health and Welfare Trust Fund. I understand that if my Employer cannot deduct this amount from my paycheck, I will be billed for the Employee Contribution amount, and that it is my responsibility to make timely payments to the UFCW Northern California and Drug Employers Health and Welfare Trust Fund by the due date indicated on the bill.

I understand that, in order to maintain 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 Employee Contribution in advance of the month of coverage.

PLEASE PRINT CLEARLY

Name (Last)	(First)	M.I.	Union Local

MEMBER SOCIAL SECURITY NUMBER	Date of Birth	☐ Male ☐ Female	Home Phone Number

SIGNATURE	**DATE**

Forms are to be returned to:

UFCW & Employers Trust LLC.,
P.O. Box 4100
Concord, CA 94520-4100
Fax: (925) 746-7549

v.001 20190213