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UEBT ACTIVE PREMIER BENEFIT LEVEL ENROLLMENT FORM 4

INSTRUCTIONS PLEASE READ AND COMPLETE ALL INFORMATION ON THIS FORM THAT APPLY TO YOUR HOUSEHOLD									
ELIGIBILITY FOR ALL PERSONS LI	STED SHALL BE S	SUBJECT TO ALL PROVISIONS AI	ND LIMITATIONS	OF THE TRUST	AGREEMENT A	ND PLAN DOCUMENT	AS WELL AS TO ANY RULES OR RE	GULATIONS AD	OPTED BY THE BOARD OF TRUSTEES
SECTION 1		FOR ENROLLMENT							
PLEA			LOW TO IND				ER OR A CHANGE ENRO		QUEST
	L NEW			_		RITAL STATUS			
	DATE OF H			_	IGE OF DEP		**TRANSFER FRO		
	LI *RETU	URN FROM MILITARY			IGE OF CAR		PRIOR JOB LOCATION/	LOCAL:	
				L CHAN	IGE OF NAM		DATE OF TRANSFER:	PROCAL FUN	D IS SOUTHERN CALIFORNIA
* RETURN FROM	MILITARY =	ATTACH A COPY OF FOR	RM DD-2214		110		ICHERS, ATTACH A REQUE		
SECTION 2	COVERAC	GE SELECTION PLEASE	e note: if yo	U MAKE A B	SENEFIT SELE	CTION THAT IS NO	OT CURRENTLY AVAILABLE	ΤΟ ΥΟυ, ΥΟΙ	JR REQUEST WILL BE DENIED
MEDICAL PLAN SELECTION:					DENTAL PLA	AN SELECTION:			
BLUE SHIELD PLAN (PPO)		🗌 KAISER PLAN (HM				CIGNA DENTAL	. 🗌 DELTA DENT	AL	
			0)			CYPRESS DENT	AL LIBERTY DEN	ITAL	
SECTION 3	MEMBER	INFORMATION			1	7			
Last Name		First Name		Middle Initial	Gender		Member ID # / SSN		Union Local Number
Mailing Address (Street or P.O. Box)				City			State	Zip Code	
о , , , , , , , , , , , , , , , , , , ,									
Date of Birth		Current Marital Status					Date of Marriage / Divorce / Do	omestic Partner	Certification
		□ Never Married □N			ner 🗌 Divor	ced 🗆 Widowed			
Cell Phone Number			Home Telephor	ne Number			Email Address		
SECTION 4	DEPENDE		(For additional	dependents, v	write on the bo	ack of this form)			
TO ADD, CHANGE OR REMO							ON SPECIFICATIONS FO	RM	
Last Name		First Name		Relationship	-	Gender	Date of Birth	1	Dependent Social Security #
1									
SECTION 5		ARY OF DEATH BENI							
Complete a Death Beneficia	ry Change F	orm for all subsequen	it changes (a				the Member or Denor		al % Allocated must = 100%
	ry Change F	orm for all subsequen	t changes (a by the Trust		e more tha		the Member or Depend Social Security # or Tax ID #		
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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



SECTION 1: INSTRUCTIONS

Why Does Other Insurance Information Matter?

Other Insurance can be defined as any other medical insurance, dental insurance, or prescription coverage that you or your dependents may have through an insurance policy other than the health benefits provided by the Plan.

For example, you may cover your dependent child under your health benefits provided by the Plan and at the same time, your Spouse/Domestic Partner may cover the same child under health insurance provided through your Spouse/Domestic Partner's own employer.

The Trust Fund needs to know if you, your Spouse/Domestic Partner and/or your dependent children are covered under any other health insurance so that we can coordinate payment of your health benefits. This will ensure your claims are paid correctly and on time.

SECTION 2: MY INFORMATION

Please provide your basic identification information

First Name	Last Name	Member ID # / SSN
Address		
City	Zip	State
Home Phone	Cell Phone	Union Local

SECTION 3: COMPANY LETTER INQUIRY

Your Spouse/Domestic Partner is required to take other health insurance if insurance is offered by your Spouse/Domestic Partner's current or former employer. If your Spouse/Domestic Partner's employer does not offer insurance, you will be required to send the Trust Fund Office a letter on that employer's company letterhead stating that no insurance is offered. This letter is due back to the Trust Fund Office no later than 30 days from the date of this signed form.

□ ✓ Check this box if your Spouse/Domestic Partner (if applicable) is currently employed.

If this box is ✓ checked, you will need to supply a letter from your Spouse/Domestic Partner's current employer on their company letterhead stating that no insurance is offered by the employer. Or if health insurance is offered by your Spouse/Domestic Partner's current or former employer, and your Spouse/Domestic Partner is enrolled in such insurance, please provide the other insurance information in **Section 4** *below*. If your Spouse/Domestic Partner's current or former employer offers health insurance, but your Spouse/Domestic Partner is not enrolled in such insurance, it is your responsibility to report this to the Trust Fund Office immediately.

SECTION 4: PROVIDE OTHER INSURANCE POLICY INFORMATION

If anyone in your family, including yourself, has other insurance, please fill out the insurance policy information and who is covered under that other insurance policy. Your family may have more than one other insurance policy, we ask that you provide the TFO with the details for each individual insurance policy.

Please \checkmark check whether the insurance is provided by an employer, the government, or \checkmark check "Any Other Coverage" if it is another type of health benefit coverage not listed.

If you have no other insurance coverage, please ✓ check "None" and remember to initial and sign the last page of this questionnaire.

Log into ufcwtrust.com to view your personal benefit information.

The Health & Welfare Services Department is available Monday - Friday, 8:00 AM - 5:00 PM at (800) 552-2400 • Fax: (925) 746-7549



ACTIVE OTHER INSURANCE INFORMATION FORM

POLICY # 1 DETAILS CONTINUED FROM PAGE 1 (if applicable)					
Check "None" if there are no other insurance policies for you or your enrolled dependents None					
Who is the main Subscriber for this other insurance policy?	Is this for an Active or Retiree Plan?				
	Active Plan				
Who is covered under this policy (if any), list any family members that are	e covered under this insurance policy?				
What type of policy is this? Employer Insurance Government	Insurance Any Other Coverage				
	Part C				
What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)?					
If this Medical Insurance is an HMO, \checkmark check this box \Box					
What is the effective start date for the Medical Insurance?					
What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)?					
If this Dental Insurance is an HMO, \checkmark check this box \Box					
What is the effective start date for the Dental Insurance?					
What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision / Optur	m)?				
If this Prescription (Rx) Insurance is an HMO, \checkmark check this box \Box					
What is the effective start date for the Prescription (Rx) Insurance?					
POLICY # 2 DETAILS (if applicable)					
Check "None" if there are no other insurance policies for you or your enrolled dependents None					
Who is the main Subscriber for this other insurance policy?	Is this for an Active or Retiree Plan?				
	Active Plan 🛛 Retiree Plan 🗆				
Who is covered under this policy (if any), list any family members that are	e covered under this insurance policy?				
What type of policy is this? Employer Insurance Government	Insurance 🛛 Any Other Coverage 🗆				
If Medicare, what part(s)? Part A Part B	Part C				
What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)?					
If this Medical Insurance is an HMO, \checkmark check this box \Box					
What is the effective start date for the Medical Insurance?					



ACTIVE OTHER INSURANCE INFORMATION FORM

What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)?				
If this Dental Insurance is an HMO, \checkmark check this box \Box				
What is the effective start date for the Dental Insurance?				
What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision / Optum)?				
If this Prescription (Rx) Insurance is an HMO, \checkmark check this box \Box				
What is the effective start date for the Prescription (Rx) Insurance?				
POLICY # 3 DETAILS (if applicable)				
Check "None" if there are no other insurance policies for you or your en	rolled dependents None			
Who is the main Subscriber for this other insurance policy?	Is this for an Active or Retiree Plan?			
	Active Plan \Box Retiree Plan \Box			
Who Is Covered under this policy (if any), list any family members the	hat are covered under this insurance policy?			
What type of policy is this? Employer Insurance Govern	ment Insurance Any Other Coverage			
If Medicare, what part(s)? Part A Part B	Part C			
What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaise	er)?			
If this Medical Insurance is an HMO, \checkmark check this box \Box				
What is the effective start date for the Medical Insurance?				
What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)?				
If this Dental Insurance is an HMO, \checkmark check this box \Box				
What is the effective start date for the Dental Insurance?				
What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision /	[′] Optum)?			
If this Prescription (Rx) Insurance is an HMO, \checkmark check this box \Box				
What is the effective start date for the Prescription (Rx) Insurance?				
Any Other Policy Details (if applicable), Please us	e the backside of this form.			



ACTIVE OTHER INSURANCE INFORMATION FORM

SECTION 5: SIGNATURE AND 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 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 ACKNOWLEDGE AND UNDERSTAND THAT I AM LIABLE FOR ALL CLAIMS FOR DEPENDENTS DEEMED INEI	JGIBLE.
Initial Here		
Initial Here	I ACKNOWLEDGE AND UNDERSTAND THAT IF MY ENROLLED SPOUSE/DOMESTIC PARTNER HAS ACCESS TO CURRENT OR FORMER EMPLOYMENT, MY SPOUSE/DOMESTIC PARTNER MUST ENROLL IN THE PLAN THA THE UEBT ACTIVE PLAN OR MY SPOUSE/DOMESTIC PARTNER BENEFITS WILL BE REDUCED. IF MY SPOUSE NOT OFFER MEDICAL AND/OR DENTAL COVERAGE, A LETTER FROM MY SPOUSE/DOMESTIC PARTNER'S E THAT COVERAGE IS NOT AVAILABLE.	T IS AT LEAST AS COMPREHENSIVE AS /DOMESTIC PARTNER'S EMPLOYER DOES
X	Member's Signature:	Date:
Sign Here		
X	Spouse/Domestic Partner's Signature (if applicable):	Date:
Sign Here		
	This form cannot be accepted if it is not signe	d!
For qu	uestions or concerns please contact the Health and Welfare Services departme	nt at 1-800-552-2400



Mail: P.O. Box 4100 • Concord, CA 94524 –4100 Telephone: (800) 552-2400 • Facsimile: (925) 746-7549 www.ufcwtrust.com

UFCW & EMPLOYERS BENEFIT TRUST AUTHORIZATION FOR PAYROLL DEDUCTION FOR EMPLOYEE PREMIUM CONTRIBUTION

NAME _____

LAST 4 DIGITS OF SOCIAL SECURITY NO.____

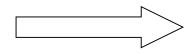
(PLEASE PRINT)

I hereby request the Trust Fund Office (TFO) establish coverage for the dependents I am enrolling under the UFCW & Employers Benefit 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 & Employers Benefit Trust Fund. If I qualify for participation in the Wellness Program, sometimes referred to as Health Care Partnership (or "HCP"), my Wellness Program (HCP) premium amount for coverage of my enrolled dependents will be the weekly amount shown on the back of this page under the heading "Wellness Program Premiums" based on the number of dependents enrolled on my plan. I acknowledge that if I do not complete all of the Wellness Steps required to be eligible to participate in the Wellness Program (HCP), I will be deemed to have instead elected not to participate in the Wellness Program. If I am not eligible to participate in the Wellness Program, my Non-Wellness Program premium amount for coverage of my enrolled dependents will be the weekly amount shown on the back of this page under the heading "Non-Wellness Program Premiums" based on the number of dependents enrolled on my plan. 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 & Employers Benefit Trust Fund by the applicable due date, or coverage of my dependents will 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 I do not make any election changes and if the premium amounts for coverage remain the same. I also understand that I cannot change my coverage elections 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 elections 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 based on your current Plan level and the elections made during the Graduation process:

Level of Coverage	Weekly Rates				
Premier Plan - PPO					
Wellness Program (HCP) Premiums	Employee	\$0 (I	only want coverage for myself)		
	□ Spouse/Domestic Partner	\$20	□ 1 Child	\$10	
	□ 2 Children	\$20	\Box 3 Children or more	\$30	
Non-Wellness Program Premiums	□ Employee	\$0 (I	only want coverage for myself)		
	□ Spouse/Domestic Partner	\$30	□ 1 Child	\$15	
	□ 2 Children	\$30	\Box 3 Children or more	\$45	
Premier Plan - Kaiser	•				
Wellness Program (HCP) Premiums	Employee	\$0 (I	only want coverage for myself)		
	□ Spouse/Domestic Partner	\$20	□ 1 Child	\$10	
	□ 2 Children	\$20	□ 3 Children or more	\$30	
Non-Wellness Program Premiums	Employee	\$0 (I	only want coverage for myself)		
	□ Spouse/Domestic Partner	\$30	□ 1 Child	\$15	
	□ 2 Children	\$30	□ 3 Children or more	\$45	

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

 SIGNATURE:



Mail: P.O. Box 4100 Concord, CA 94524-4100 Telephone: (800) 552-2400 Facsimile: (925) 746-7549 <u>www.ufcwtrust.com</u>

UEBT ACTIVE FORM 7

	, CHANGE, OR REMOVE COVERAGE FOR DEPENDENTS, A COPY OF THE FOLLOWING DOCUME AL DOCUMENTS WILL NOT BE RETURNED.)	ENTATION IS REQUIRED (PLEASE NOTE	
	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 	STANDARD MEMBER = DOCUMENTATION MUST BE SUBMITTED WITHIN 31 DAYS OF QUALIFYING EVENT ULTRA MEMBER = WITHIN 90 DAYS OF	
DOMESTIC PARTNER:	CERTIFICATE OF REGISTRATION OF DOMESTIC PARTNERSHIP (CRDP) ISSUED BY THE CALIFORNIA SECRETARY OF STATE AND: RECENT (WITHIN 60 DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR DOMESTIC PARTNER'S NAME AT YOUR ADDRESS	QUALIFYING EVENT • PREMIER MEMBER = WITHIN 90 DAYS OF QUALIFYING EVENT (60 DAYS FOR HMO ENROLLMENT)	
	COUNTY-ISSUED BIRTH CERTIFICATE	NEWBORN CHILD	
NEWBORN CHILD:	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.	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	
STEPCHILD:	 COUNTY-ISSUED BIRTH CERTIFICATE PLUS: COUNTY-ISSUED MARRIAGE CERTIFICATE WITH NATURAL PARENT 	• STANDARD/ULTRA MEMBER = WITHIN DAYS OF QUALIFYING EVENT OR DATE OF PLACEMENT (FOSTER/ADOPTION)	
ADOPTED CHILD:	COURT ADOPTION PAPERS	• PREMIER MEMBER = WITHIN 90 DAYS OF	
FOSTER CHILD:	 FOSTER HOME LICENSE PLUS: LEGAL GUARDIANSHIP PAPERS FOR THE CHILD 	QUALIFYING EVENT (60 DAYS FOR HMO ENROLLMENT) OR DATE OF PLACEMENT (FOSTER/ADOPTION)	
OVERAGE DISABLED DEPENDENT: (Must be renewed annually)	 DISABLED OVERAGE DEPENDENT CHILD FORM GO TO WWW.UFCWTRUST.COM TO DOWNLOAD THE FORM OR CALL 1-800-552-2400 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 CONSUMERT. NEWBORN CHILD, NATURAL CHILD, STEPCHILD, ADOPTED CHILD, OR FOSTER CHILD TO ADD A DEPENDENT BECAUSE OF CURRENT LOSS OF COVE 		
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:	ANY DEPENDENT TYPE • LOSS OF COVERAGE = WITHIN 30 DAYS FROM LOSS OF COVERAGE	
	A HIPAA CERT OR A COBRA NOTICE TO PROVE LOSS OF COVERAGE		
WHEN ADD	ING A DEPENDENT PLEASE ATTACH A COMPLETED OTHER INSURANCE 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 PAPER	NORK	
DEPENDENT DEATH:	CERTIFIED DEATH CERTIFICATE		
	PLEASE MAIL YOUR DOCUMENTS TO:		
	UFCW & EMPLOYERS TRUST, LLC P.O. BOX 4100		
	Concord, CA 94524-4100		