UFCW TRUST
Working For Your Benefit

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

UEBT RETIREE
RETIREE BENEFIT LEVEL
ENROLLMENT FORM 5

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 — COVERAGE SELECTION

PLEASE NOTE: IF YOU MAKE A BENEFIT SELECTION THAT IS NOT CURRENTLY AVAILABLE TO YOU, YOUR REQUEST WILL BE DENIED

IF YOU CHOOSE TO ENROLL YOUR SPOUSE/DOMESTIC PARTNER AND/OR ELIGIBLE DEPENDENT CHILDREN, THEY WILL BE COVERED UNDER THE SAME OPTIONS YOU ELECT FOR YOURSELF

MEDICAL PLAN SELECTION:

IN STATE CALIFORNIA & NON-MEDICARE ONLY:	OUT OF STATE CALIFORNIA & NON-MEDICARE ONLY:
☐ BLUE SHIELD PLAN (PPO) ☐ KAISER PLAN (HMO)	☐ BLUE SHIELD BLUE CARD PLAN (PPO)

IN STATE CALIFORNIA & MEDICARE ONLY:	OUT OF STATE CALIFORNIA & MEDICARE ONLY:
For any MEDICARE Plan, all enrolled participants must be enrolled in Medicare.	
☐ UEBT RETIREE INDEMNITY MEDICARE PLAN ☐ KAISER PLAN (HMO) ☐ HEALTH NET PLAN (HMO)	☐ UEBT RETIREE INDEMNITY MEDICARE PLAN ☐ UNITEDHEALTHCARE PLAN (PPO)

DENTAL PLAN SELECTION:

☐ CIGNA DENTAL ☐ CYPRESS DENTAL ☐ DELTA DENTAL

I AM DECLINING DENTAL COVERAGE FOR:

☐ **RETIREE HOUSEHOLD**

Upon declining Dental, you must wait for two Open Enrollments to re-enroll in Dental.

DENTAL PLAN: PLEASE CHECK THE APPROPRIATE BOX ABOVE TO ELECT OR DECLINE DENTAL COVERAGE FOR YOURSELF AND DEPENDENTS. IF YOU ENROLL A SPOUSE/DOMESTIC PARTNER OR ELIGIBLE DEPENDENT CHILD UNDER THE MEDICAL PLAN YOU MUST ALSO ENROLL THOSE SAME DEPENDENTS UNDER THE DENTAL PLAN. IF YOU ARE A SELF-PAY RETIREE AND ARE DECLINING DENTAL, YOU ARE ALSO DECLINING VISION & HEARING COVERAGE.

MEDICAL PLAN: PLEASE NOTE, IF YOU OR YOUR ENROLLED DEPENDENTS ARE NON-MEDICARE AND CURRENTLY RESIDE OUTSIDE OF CALIFORNIA, THE ONLY MEDICAL PLAN AVAILABLE IS THE BLUE SHIELD BLUECARD PLAN (PPO). IF YOU REQUEST ANY OTHER MEDICAL PLAN LISTED YOUR REQUEST WILL BE DENIED. (YOU MUST ELECT MEDICAL COVERAGE TO BE ELIGIBLE FOR OPTIONAL DENTAL COVERAGE).

I AM DECLINING MEDICAL COVERAGE FOR: ☐ RETIREE ☐ SPOUSE/DOMESTIC PARTNER

I understand that if I and/or my spouse or domestic partner decline medical coverage for any reason other than because I and/or my spouse or domestic partner are enrolled in other group health coverage (not an individual Plan or Medicare), I and/or my spouse or domestic partner will be prohibited from ever enrolling again in the Plan. If I and/or my spouse/domestic partner request to enroll in the Plan after the other group health coverage ends, I must provide proof of other group health coverage within 60 days of the date the other group health coverage ends or during the first Open Enrollment period after the other group health coverage ends, or I and/or my spouse/domestic partner forfeit participation in the Plan forever. **INITIAL**_____

SECTION 2 — MEMBER INFORMATION

Last Name	First Name	Middle Initial	Gender	Member ID # / SSN	Union Local Number

Mailing Address (Street or P.O. Box) Please do not use a P.O. Box if you elected a Medicare Plan	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 3 — SPOUSE / DOMESTIC PARTNER / DEPENDENT CHILDREN INFORMATION *(For additional dependents, write on an attached document)*

TO ADD, CHANGE OR REMOVE COVERAGE FOR DEPENDENTS PLEASE REFER TO THE ATTACHED DOCUMENTATION SPECIFICATIONS FORM

Last Name	First Name	Relationship	Gender	Date of Birth	Dependent Social Security #

SECTION 4 — BENEFICIARY OF DEATH BENEFIT

Death benefit is for Self-Pay Retirees only. Please contact the Trust Fund Office if you would like to setup a beneficiary for your Death Benefit.

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SECTION 5 — MEDICARE AND END-STAGE RENAL DISEASE (ESRD) *(Please Complete Entirely if electing a Medicare Only Plan from Section 1)*

MEMBER MEDICARE INFO:

SAMPLE MEDICARE CARD: Please fill cut as it appears on your card.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

SPOUSE/DOMESTIC PARTNER MEDICARE INFO:

SAMPLE MEDICARE CARD: Please fill out as it appears on your card.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

MEDICARE CLAIM NUMBER

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) _____

MEDICAL (PART B) _____

If you have enrolled dependents, please provide their Medicare and/or ESRD information, if any, on an attached document.

END-STAGE RENAL DISEASE (ESRD)

Do you have End-Stage Renal Disease (ESRD)?
☐ Yes ☐ No
If "Yes", how long have you been on Medicare for ESRD?
Start Date: MM/DD/YYYY **End Date:** MM/DD/YYYY

Does your Spouse/Domestic Partner have End-Stage Renal Disease (ESRD)?
☐ Yes ☐ No
If "Yes", how long have you been on Medicare for ESRD?
Start Date: MM/DD/YYYY **End Date:** MM/DD/YYYY

If you answered "Yes" to this question and you do not need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis any longer or you have had a successful transplant.

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 Health and Welfare Services department at 1-800-552-2400

TO BE COMPLETED BY TRUST FUND OFFICE PERSONNEL ONLY

RETIREMENT DATE: _____
RHW EFFECTIVE DATE: _____
MEDICAL ELECTIONS: K / BS / HN (CIRCLE ONE)
DENTAL ELECTIONS: DD / IND / ND (CIRCLE ONE)

PROCESSED BY: _____
DATE PROCESSED: _____
MEDICARE: ☐ YES ☐ NO

This Section intentionally left blank.
Please provide any further dependent information related to Medicare and/or ESRD, if applicable, on an attached document.

UEBT RETIREE OTHER INSURANCE INFORMATION FORM

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 their health insurance through their own employer.

The Trust Fund needs to know if any other insurance is being provided so 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 and your dependent child(ren), if any, are required to take other health insurance if insurance is offered by your Spouse/Domestic Partner's or your dependent child(ren)'s current or former employer. In addition, if you (the Retiree) are currently employed and your employer offers health insurance, you are also required to take other insurance. If your employer, or your Spouse/Domestic Partner's or dependent child(ren)'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 you are currently employed.**

☐ ✓ **Check this box if your Spouse/Domestic Partner, or your dependent child(ren) (if applicable) is/are currently employed.**

If any of the boxes above are ✓ checked, you will need to supply a letter from that current employer on their company letterhead stating that no insurance is offered by the employer. Or if health insurance is offered and taken, please provide the other insurance information in Section 4 below. If your current employer, or your Spouse/Domestic Partner's or dependent child(ren)'s current or former employer, offers health insurance, but, you, your Spouse/Domestic Partner or dependent child(ren) is/are 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 ✓check whether the insurance is provided by an employer, the government, or ✓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.***

UEBT RETIREE OTHER INSURANCE INFORMATION FORM

POLICY # 1 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 covered under this insurance policy?

POLICY # 1 DETAILS CONTINUED FROM PAGE 1 (if applicable)

What type of policy is this? Employer Insurance ☐ Government Insurance ☐ Any Other Coverage ☐

If Medicare, what part(s)? Part A ☐ Part B ☐ Part C ☐ Part D ☐

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this 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, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Elixir / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this 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 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 ☐ Part D ☐

UEBT RETIREE OTHER INSURANCE INFORMATION FORM

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this 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, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Elixir / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this 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 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 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 ☐ Part D ☐

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this 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, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Elixir / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Prescription (Rx) Insurance? _____

Any Other Policy Details (if applicable), Please use the backside of this form.

UEBT RETIREE OTHER INSURANCE INFORMATION FORM

SECTION 5: SIGNATURE AND 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.

_____ *Initial Here*	I ACKNOWLEDGE AND UNDERSTAND THAT I AM LIABLE FOR ALL CLAIMS FOR DEPENDENTS DEEMED INELIGIBLE.	
_____ *Initial Here*	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 UEBT 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*	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*	I ACKNOWLEDGE AND UNDERSTAND THAT IF ANY OF MY ENROLLED DEPENDENT CHILDREN HAVE ACCESS TO BENEFITS THROUGH THEIR OWN CURRENT OR FORMER EMPLOYMENT, THAT DEPENDENT CHILD MUST ENROLL IN THEIR 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.	
X *Sign Here*	Member's Signature:	Date:
X *Sign Here*	Spouse/Domestic Partner's Signature (if applicable):	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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AUTHORIZATION TO DEDUCT RETIREE HEALTH CARE PREMIUMS FROM MONTHLY PENSION PAYMENT CHECKS

NAME _____**SOCIAL SECURITY NO.** _____

I hereby authorize **UFCW & Employers Trust, LLC** to deduct the retiree premium amount due for health care coverage (i.e. medical, vision, and/or dental coverage) provided to me and/or my dependents through the **UFCW & Employers Benefit Trust Retiree Health Plan (Retiree Plan)** from my pension payments from the **UFCW-Northern California Employers Joint Pension Plan**.

I further authorize the **UFCW & Employers Trust, LLC** to deduct from my first pension payment the amount owed to the Retiree Plan for health care premium payments that have accrued monthly since the start of my UEBT Retiree Health and Welfare plan coverage for the benefit option(s) elected on my Retiree Plan enrollment application.

I understand and acknowledge that:

- subsequent monthly pension payments made after my first pension payment will be reduced to the amount equal to the monthly health care premium payment owed to the **Retiree Plan** for the benefit option(s) elected on my **Retiree Plan** enrollment application;
- if the **UFCW & Employers Trust, LLC** cannot deduct the required amount for the Retiree Plan premiums from my first pension payment or any subsequent pension payments, the **UFCW & Employers Trust, LLC** will bill me directly for the required premium amount;
- if the required premium amount cannot be deducted from my pension check, it is my responsibility to make timely payments directly to the **Retiree Plan** by the applicable due date, or my coverage may be suspended, and if this occurs, I may be prohibited from resuming coverage under the **Retiree Plan** forever;
- this authorization is fully revocable on a prospective basis by me at any time by providing written notice of such revocation to the **UFCW & Employers Trust, LLC** in such time and in such manner as to offer the **UFCW & Benefit Trust Retiree Health Plan** and **UFCW-Northern California Employers Joint Pension Plan** a reasonable opportunity to act on it;
- unless otherwise revoked by me in writing as described above, this authorization will remain in full force and effect even if and when: (i) the Board of Trustees of the **Retiree Plan** changes the monthly premium amount due for my elected benefit option(s) under the **Retiree Plan** in the future and provides me notice of any such changes, (ii) I later switch benefit option(s) under the **Retiree Plan**, or (iii) the Board of Trustees of the **Retiree Plan** replaces any of my elected benefit options with other benefit options offered through the Retiree Plan and provides me notice of any such changes; and
- if my monthly premium under the **Retiree Plan** ever exceeds my monthly pension benefit, the **UFCW & Employers Trust, LLC** may cancel this authorization to deduct and bill me directly for the entire premium.

NAME: _____
(PLEASE PRINT)

SIGNATURE: _____ DATE: _____