

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

UCBT ACTIVE STANDARD BENEFIT LEVEL ENROLLMENT FORM 2

	STED SHALL BE SUBJECT TO ALL PROVISIONS AN		AGREEMENT AND PLAN	DOCUMENT A	S WELL AS TO ANY RULES OR REC	ULATIONS ADO	OPTED BY THE BOARD OF TRUSTEES
SECTION 1	PURPOSE FOR ENROLLMENT F						0.11507
PLEA	SE CHECK ONE OF THE BOXES BEL						QUEST
		_	IGE OF MARITAL S				
	DATE OF HIRE:		NGE OF DEPENDE	NTS	**TRANSFER FROM		
	*RETURN FROM MILITARY	L CHAN	IGE OF NAME		PRIOR JOB LOCATION/I	.OCAL:	
			1		DATE OF TRANSFER:		
* RETURN FROM	MILITARY = ATTACH A COPY OF FORM	/I DD-2214					D IS SOUTHERN CALIFORNIA
					CHERS, ATTACH A REQUES		
SECTION 2	COVERAGE SELECTION PLEASE	NOTE: IF YOU MAKE A B				0 100, 100	JR REQUEST WILL BE DENIED
MEDICAL PLAN SELECTION:			DENTAL PLAN SEL	ECTION:			
BLUE SHIELD INDEMNITY	PLAN (PPO)		CIGNA DENT	AL	CYPRESS DENTAL] DELTA DE	NTAL
SECTION 3	MEMBER INFORMATION						
Last Name	First Name	Middle Initial	Gender		Member ID # / SSN		Union Local Number
Mailing Address (Street or P.O. Box)		City			State	Zip Code	
Date of Birth	Current Marital Status	·			Date of Marriage / Divorce / Do	mestic Partner	Certification
		arried 🛛 Domestic Part	ner \Box Divorced \Box	Widowed			
Cell Phone Number		Home Telephone Number			Email Address		
SECTION 4	DEPENDENT INFORMATION (F						
TO ADD, CHANGE OR REMO	VE COVERAGE FOR DEPENDENTS F	PLEASE REFER TO THE	ATTACHED DOCU	JMENTATIO	ON SPECIFICATIONS FOR	M	
A SPOL	JSE/DOMESTIC PARTNER MAY ONLY	BE ADDED TO COVERAG	E WHEN A STANDA	ARD MEMBE	R HAS MET 1200 QUALIFY	ING WORKE	D HOURS
Last Name	First Name	Relationship	Gende	r	Date of Birth		Dependent Social Security #
SECTION 5	BENEFICIARY OF DEATH BENE	FIT					
Complete a Death Beneficia	ry Change Form for all subsequent	changes (available at v	www.ufcwtrust.com	ı)		Tota	I % Allocated must = 100%
	e Death Benefit claim is received b			<u>year</u> after		ent's death	
Beneficiary's Last Name	First Name	Middle Initial	Relationship		Social Security # or Tax ID #		Percentage (%) Allocated
Street Address	I	City				State	Zip Code
		City				State	
Beneficiary's Last Name	First Name	Middle Initial	Relationship		Social Security # or Tax ID #		Percentage (%) Allocated
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Street Address		City	ļ			State	Zip Code
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SECTION 6	MEMBER / PARTICIPANT CERTI	FICATION (Please Pa	ead and Sian Bela	w)			
FRAUD NOTICE: UNDERSTAND]			-	,	URANCE ACT IF I KNOWINGL	Y PROVIDE A	NY MATERIALLY FALSE INFORMATION
	THAT I MAY BE SUBJECT TO CIVIL AND/OR	CRIMINAL PENALTIES FOR	COMMITTING A FRA	UDULENT INS	URANCE ACT IF I KNOWINGL	Y PROVIDE A	NY MATERIALLY FALSE INFORMATION
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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 / 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 # 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, ✓ check this 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 B Part C Part D Part D				
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 / 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 use 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 INELI	GIBLE.
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 THAT THE UCBT ACTIVE PLAN OR MY SPOUSE/DOMESTIC PARTNER BENEFITS WILL BE REDUCED. IF MY SPOUSE/I NOT OFFER MEDICAL AND/OR DENTAL COVERAGE, A LETTER FROM MY SPOUSE/DOMESTIC PARTNER'S EM THAT COVERAGE IS NOT AVAILABLE.	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 signed	!!
For qu	uestions or concerns please contact the Health and Welfare Services departmer	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 COMPREHENSIVE BENEFITS TRUST AUTHORIZATION FOR PAYROLL DEDUCTION FOR EMPLOYEE PREMIUM CONTRIBUTION

NAME _____

LAST 4 DIGITS OF SOCIAL SECURITY NO.____

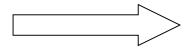
(PLEASE PRINT)

I hereby request the Trust Fund Office (TFO) establish coverage for the dependents I am enrolling under the UFCW Comprehensive Benefits 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 Comprehensive Benefits Trust Fund. 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 Comprehensive Benefits Trust Fund by the applicable due date, or coverage of my dependents may 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 no election changes are made and the premium amounts remain the same. I also understand that I cannot change my coverage election 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 election 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			
Standard Plan				
	Employee	\$0 (I on	ly want coverage for myself)	
	□ 1 Child □ 2 Children	\$20 \$40	□ 3 Children or more	\$60

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

 SIGNATURE:
 Date:

INSTRUCTIONS

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

(PLEASE NOTE ORIGINAL DOCUMENTS WILL NOT BE RETURNED.)

TO ADD. CHANGE. OR REMOVE COVERAGE FOR DEPENDENTS. A COPY OF THE FOLLOWING DOCUMENTATION IS REQUIRED

TO ADD A DEPENDENT DOCUMENTATION REQUIREMENT TIMELINE REQUIREMENT COUNTY ISSUED MARRIAGE CERTIFICATE AND ONE OF THE FOLLOWING: SPOUSE OR DOMESTIC PARTNER PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN WITH YOUR SPOUSE LISTED OR • STANDARD MEMBER = DOCUMENTATION SPOUSE: ACKNOWLEDGMENT OF YOUR TAX EXTENSION (FORM 4868) MUST BE SUBMITTED WITHIN 31 DAYS OF (PLEASE COVER UP FINANCIAL INFORMATION) QUALIFYING EVENT RECENT (WITHIN 60 DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR • ULTRA/PREMIER MEMBER = WITHIN 90 DAYS OF QUALIFYING EVENT (60 DAYS FOR HMO SPOUSE'S NAME AT YOUR ADDRESS ENROLLMENT) CERTIFICATE OF REGISTRATION OF DOMESTIC PARTNERSHIP (CRDP) ISSUED BY THE CALIFORNIA SECRETARY OF STATE DOMESTIC PARTNER: AND: RECENT (WITHIN 60 DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR DOMESTIC PARTNER'S NAME AT YOUR ADDRESS COUNTY-ISSUED BIRTH CERTIFICATE NEWBORN CHILD • STANDARD MEMBER = WITHIN 90 DAYS OF NOTE: If you do not have the County Issued Birth Certificate by stated deadlines, submit the Hospital DATE OF BIRTH Issued Birth Certificate and proof that you applied for your child's County Birth Certificate within 60 NEWBORN CHILD: • ULTRA/PREMIER MEMBER = WITHIN 90 DAYS days of the date of birth (for both PPO or HMO) for six months of temporary coverage beginning at OF DATE OF BIRTH (60 DAYS FOR HMO date of birth. The County Issued Birth Certificate must be received by the Trust Fund Office no later ENROLLMENT) than 6 months after the date of birth. NATURAL CHILD: COUNTY-ISSUED BIRTH CERTIFICATE CHILD DEPENDENT COUNTY-ISSUED BIRTH CERTIFICATE STANDARD MEMBER = WITHIN 90 DAYS OF STEPCHILD: QUALIFYING EVENT OR DATE OF PLACEMENT PLUS: COUNTY-ISSUED MARRIAGE CERTIFICATE WITH NATURAL PARENT (FOSTER/ADOPTION) ADOPTED CHILD: • ULTRA/PREMIER MEMBER = WITHIN 90 DAYS COURT ADOPTION PAPERS OF QUALIFYING EVENT (60 DAYS FOR HMO FOSTER HOME LICENSE ENROLLMENT) OR DATE OF PLACEMENT FOSTER CHILD: PLUS: (FOSTER/ADOPTION) LEGAL GUARDIANSHIP PAPERS FOR THE CHILD 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 OVFRAGE • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN SHOWING CHILD LISTED **DISABLED DEPENDENT:** PLUS (Must be renewed annually) • ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS CHILD BELONGS: NATURAL CHILD, STEPCHILD, ADOPTED CHILD, OR FOSTER CHILD TO ADD A DEPENDENT BECAUSE OF CURRENT LOSS OF COVERAGE ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS DEPENDENT BELONGS: SPOUSE, DOMESTIC PARTNER, NEWBORN, NATURAL CHILD, STEPCHILD, ANY DEPENDENT TYPE ADOPTED CHILD, FOSTER CHILD OR OVERAGE DISABLED DEPENDENT CHILD LOSS OF COVERAGE = WITHIN 30 DAYS FROM ANY DEPENDENT TYPE: PLUS: LOSS OF COVERAGE • A HIPAA CERT OR A COBRA NOTICE TO PROVE LOSS OF COVERAGE WHEN ADDING A DEPENDENT PLEASE ATTACH A COMPLETED OTHER INSURANCE INFORMATION SURVEY AND AN AUTHORIZATION TO DEDUCT FORM **TO REMOVE A DEPENDENT** DIVORCE OF SPOUSE: FINAL DIVORCE DECREE ENTERED WITH THE COURT DISSOLUTION OF • FINAL JUDGMENT OF DISSOLUTION OR TERMINATION OF DOMESTIC PARTNERSHIP PAPERWORK DOMESTIC PARTNERSHIP: DEPENDENT DEATH: CERTIFIED DEATH CERTIFICATE PLEASE MAIL YOUR DOCUMENTS TO: **UFCW & EMPLOYERS TRUST, LLC** P.O. BOX 4100 Concord. CA 94524-4100

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FORM 7