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

UCBT ACTIVE ANNUAL VERIFICATION ENROLLMENT FORM 2

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 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 / Domestic Partner Certification
	☐ Never Married ☐Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	

Cell Phone Number	Home Telephone Number	Email Address

SECTION 2 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 the Health and Welfare Services department at 1-800-552-2400

ACTIVE 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 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 ✓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.

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 ☐ 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. Envision / 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 ☐

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? _____

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, ✓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. Envision / 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.

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, 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.

_____ ***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 CURRENT 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.	
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