LOCAL 371 UFCW

AMALGAMATED WELFARE TRUST FUND

2020 FULL TIME BENEFIT ENROLLMENT FORM

ALL 4 PAGES MUST BE COMPLETED

SECTION A: MEMBER INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE

SEX MALE FEMALE	MARITAL STATUS M S D W	LAST 4 OF SOC SEC #	EMPLOYER

HOME PHONE	CELL PHONE	WORK PHONE

ARE YOU COVERED BY ANY OTHER INSURANCE? YES NO	ARE YOU COVERED BY MEDICARE? YES NO

MEDICARE ID NUMBER	MEDICARE EFFECTIVE DATE	MEDICARE PLAN ENROLLED IN A B D

SECTION B: MAKE AN ELECTION FOR BENEFITS

MEDICAL, DENTAL, VISION, RX, HEARING AID, DISABILITY AND DEATH BENEFIT ARE INCLUDED

Copy of Marriage Certificate is required for first time enrollment of spouse

Copy of Birth Certificate showing both parents are required for first time enrollment of child(ren)

COVERAGE LEVEL		WEEKLY PAYROLL DEDUCTION	
Full Time Employee Only	☐	REFER TO COVERSHEET FOR AMOUNTS	
Full Time Employee plus Spouse	☐	REFER TO COVERSHEET FOR AMOUNTS	MUST COMPLETE PAGE 2 SECTION C
Full Time Employee plus Child(ren)	☐	REFER TO COVERSHEET FOR AMOUNTS	MUST COMPLETE PAGE 2 SECTION C
Full Time Employee plus Spouse & Child(ren)	☐	REFER TO COVERSHEET FOR AMOUNTS	MUST COMPLETE PAGE 2 SECTION C
DECLINE ALL COVERAGES	☐	**IF YOU CHOOSE TO DECLINE ALL COVERAGE YOU WILL NOT BE ELIGIBLE FOR ANY OF THE BENEFITS LISTED ABOVE.** **YOU CANNOT MAKE ANY CHANGES TO THIS ELECTION LATER IN THE YEAR UNLESS YOU HAVE A QUALIFYING EVENT.**	

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SECTION C: DEPENDENT ENROLLMENT

ONLY DEPENDENTS LISTED WILL BE ENROLLED FOR UPCOMING PLAN YEAR

SPOUSE NAME	SPOUSE SOCIAL SECURITY NUMBER	SPOUSE DATE OF BIRTH

IS YOUR SPOUSE EMPLOYED	EMPLOYER NAME	DOES EMPLOYER OFFER INSURANCE	DOES SPOUSE RESIDE WITH YOU
YES NO		YES NO	YES NO

IS YOUR SPOUSE COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

DEPENDENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO MEMBER	SEX	DOES DEPENDENT RESIDE WITH YOU
			CHILD STEPCHILD OTHER	M F	YES NO

IS THIS DEPENDENT COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

DEPENDENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO MEMBER	SEX	DOES DEPENDENT RESIDE WITH YOU
			CHILD STEPCHILD OTHER	M F	YES NO

IS THIS DEPENDENT COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

DEPENDENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO MEMBER	SEX	DOES DEPENDENT RESIDE WITH YOU
			CHILD STEPCHILD OTHER	M F	YES NO

IS THIS DEPENDENT COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

DEPENDENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO MEMBER	SEX	DOES DEPENDENT RESIDE WITH YOU
			CHILD STEPCHILD OTHER	M F	YES NO

IS THIS DEPENDENT COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

DEPENDENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO MEMBER	SEX	DOES DEPENDENT RESIDE WITH YOU
			CHILD STEPCHILD OTHER	M F	YES NO

IS THIS DEPENDENT COVERED BY ANY OTHER INSURANCE INCLUDING MEDICARE? (MEDICAL, DENTAL, VISION, RX) YES NO

IF YES, YOU MUST COMPLETE PAGE 3 SECTION D

CONTINUE TO PAGE 3

SECTION D: OTHER INSURANCE INFORMATION

COORDINATION OF BENEFITS

NAME OF INSURANCE COMPANY #1	POLICY NUMBER	ORIGINAL EFFECTIVE DATE
INSURED NAME	TYPE OF COVERAGE (CIRCLE ALL THAT APPLY) MEDICAL DENTAL RX VISION	
PLEASE LIST EVERYONE COVERED BY THIS POLICY		
NAME OF INSURANCE COMPANY #2	POLICY NUMBER	ORIGINAL EFFECTIVE DATE
INSURED NAME	TYPE OF COVERAGE (CIRCLE ALL THAT APPLY) MEDICAL DENTAL RX VISION	
PLEASE LIST EVERYONE COVERED BY THIS POLICY		

YOU MUST INCLUDE COPIES OF YOUR MOST RECENT INSURANCE ID CARD FOR THE ABOVE POLICIES. IF YOU HAD PRIOR COVERAGE WHICH HAS ENDED, YOU MUST SEND A COPY OF LETTER FROM INSURANCE COMPANY SHOWING DATE COVERAGE ENDED.

Section E: If you are divorced, legally separated, a single parent or enrolling a stepchild please complete information below about the natural parent, their employer, and any insurance they carry for the dependent child.

You must submit a copy of divorce decree/court order showing custody information and responsibility for providing insurance benefits for dependent child.

1. Does the other biological parent of your dependent child(ren) provide health benefits? YES NO

   A. Full name of the other biological parent: _____ Date of Birth: _____

   Employer Name and Telephone number: _____

   If yes, please provide the following information:

   B. Name of other Insurance Plan: _____ Effective Date: _____

   Policy Number: _____

   Type of Coverage: Circle all that apply: MEDICAL DENTAL RX VISION

   Which children are covered? _____

2. Are you divorced or legally separated? YES NO If Yes Date of Divorce/separation: _____

   Are you a single parent? YES NO

CONTINUE TO SIGNATURE

PAGE 4

SECTION F: AUTHORIZATION AND SIGNATURE

PLEASE BE SURE YOU HAVE COMPLETED ALL 4 PAGES AND ALL SECTIONS ARE COMPLETE BEFORE SIGNING AND RETURNING TO

Local 371 AWTF, PO Box 470, Westport, CT 06880

I hereby acknowledge that I have made the health care elections listed on the front of this form and authorize my employer to withhold the corresponding weekly payroll deductions from my paycheck and forward the amount deducted to the Fund on my behalf. I understand I have the right to withdraw my authorization prior to the close of open enrollment. I understand that if I withdraw my authorization, my eligibility to obtain health care coverage from the Fund may be restricted. I hereby acknowledge that the information I have provided is accurate. I further understand that the Fund has the right to revoke, rescind or terminate benefits if any false or fraudulent statements are made by me or my dependents.

EMPLOYEE SIGNATURE

DATE

REMINDER CHANGES TO YOUR ELECTION ARE ONLY ALLOWED DURING OPEN ENROLLMENT OR IF YOU HAVE A QUALIFYING EVENT (MARRIAGE, BIRTH OF CHILD, ETC) DURING THE YEAR YOU MUST CONTACT THE FUND OFFICE WITHIN 30 DAYS OF A QUALIFYING EVENT TO MAKE CHANGES TO YOUR ELECTION

IF YOU NEED ANY HELP COMPLETING YOUR FORM PLEASE CALL THE FUND OFFICE AT 1-800-882-5556.