

UFCW BAY HEALTH AND WELFARE TRUST FUND
Mail: P. O. Box 8086 · Walnut Creek, CA 94596-8086
Telephone: (925) 746-7530 · (800) 794-5678 · Facsimile: (925) 746-7549

(PLEASE READ INSTRUCTIONS FIRST)

RETIREE ENROLLMENT FORM

INSTRUCTIONS Please also read the important information on the back of the form.

The Enrollment Form must be completed in order to enroll you and your spouse, if applicable, for Health & Welfare coverage. Be sure to complete **all** of the information requested on the Enrollment Form.

Please read your Summary Plan Description for descriptions of the various plans. Remember, once you make the election you will not be permitted to change your Plan until the next annual Open Enrollment period which is during the month of November each year (changes effective January 1).

TO ADD YOUR SPOUSE OR DOMESTIC PARTNER, THE FOLLOWING DOCUMENTATION IS REQUIRED

- Application must be received within 30 days from the date of marriage. Any final paperwork required to enroll your spouse must be received within 120 from your date of marriage. If all paperwork to enroll your spouse is not received within 120 days, your spouse's coverage will be effective the first of the month following the month the Trust Fund Office receives the final paperwork.
- A copy of a Certificate of Registration of Domestic Partnership must be submitted to add your domestic partner.

If you get divorced, it is your responsibility to report this change in your marital status and provide a copy of your dissolution judgment attached to this form.

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.

****Please check one of the boxes below to indicate if this is a new enrollment or a change request.**

- NEW ENROLLMENT
- CHANGE OF NAME
- CHANGE OF MARITAL STATUS
- CHANGE OF PLAN

Section 1 **COVERAGE SELECTION**

Medical Plan

I select: Kaiser* Indemnity Open Plan (PPO) Health Net

*If you select Kaiser and were previously covered by Kaiser, please provide your Kaiser Medical Record # in Section 2 and for your spouse in Section 3.

Dental/ Vision: Please check the appropriate box(es) below to choose optional coverage for yourself and spouse.

Retiree	Spouse
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision

To cover your spouse, you must also be covered under the same option

Section 2 **PARTICIPANT INFORMATION**

Last Name		First Name		Initial	Gender	Social Security #	
Mailing Address (Street or P. O. Box) <input type="checkbox"/> New				City		State	Zip Code
Telephone Number	Current Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Date of Marriage/Divorce (MM/DD/YY)	Date of Birth (MM/DD/YY)	Kaiser Medical Record# or HMO Primary Care Physician (If applicable)		

EMAIL ADDRESS (If none, please check none box): None

Section 3 **SPOUSE INFORMATION**

Last Name	First Name	Relation	Gender	Date of Birth (MM/DD/YY)	Dependent Social Security# (Required)	Kaiser Medical Record#
Spouse/Domestic Partner						

SIGNATURE REQUIRED ON BACK

Section 4 SPOUSE EMPLOYMENT AND OTHER INSURANCE

Is your spouse currently employed? Yes No If 'No', skip rest of Section 5. If 'Yes', please provide the following information:

Name of Spouse's Employer: _____ Employer's Telephone: _____

Street Address _____ City _____ State _____ Zip Code _____

Does your Spouse's Employer provide any health insurance coverage? Yes No If 'No', skip rest of Section 5.

Please note that under Plan Rules your Spouse's failure to obtain health insurance coverage provided by his/her Employer may result in a reduction of benefits provided by this Plan.

If your Spouse is enrolled in a Plan, mark the 'Yes' box and provide information about the Insurance Carrier. If your Spouse is not enrolled in a Plan, mark the 'No' box and check the appropriate box which follows.

Enrolled in Medical/Rx Plan? Yes Effective date: _____ Carrier: _____ Check here if HMO Check here if Retiree Plan
 No **Check one of the following:** Not offered by Employer Offered by Employer Employee monthly cost: \$ _____

Enrolled in Dental Plan? Yes Effective date: _____ Carrier: _____
 No **Check one of the following:** Not offered by Employer Offered by Employer Employee monthly cost: \$ _____

Enrolled in Vision Plan? Yes Effective date: _____ Carrier: _____
 No **Check one of the following:** Not offered by Employer Offered by Employer Employee monthly cost: \$ _____

Next Open Enrollment Period for Spouse's Employer Month: _____ Year: _____

Section 5 OTHER INSURANCE COVERAGE FOR YOU OR ANY ENROLLED DEPENDENT(S)

Reminder: Retirees and/or spouses are required to enroll in Medicare Part A and Part B as soon as eligible (age 65 in most cases; before age 65 if have received Social Security Disability Benefits for at least 24 months.)

For Retirees and/or Spouses under age 65	Retiree under 65: _____	Are you eligible for Medicare? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Retiree's Spouse under 65: _____	Are you receiving Social Security Disability Benefits? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Is your Spouse eligible for Medicare? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Is your Spouse receiving Social Security Disability benefits? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or your spouse covered by any other Group Insurance? If so please provide us with the name of the other carrier and who is covered. Other Carrier(s): _____ Covered Person(s): _____

Section 6 PARTICIPANT AND SPOUSE CERTIFICATION (PLEASE READ THE INFORMATION BELOW AND SIGN)

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 DEFRAUD OR MISLEAD THE TRUST FUND.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION: I AUTHORIZE MY PHYSICIAN, HOSPITAL, OR OTHER MEDICALLY DESIGNATED FACILITY TO FURNISH AN AGENT, DESIGNEE OR REPRESENTATIVE OF THE HEALTH MAINTENANCE ORGANIZATION (HMO), PREPAID PLAN LISTED ABOVE, 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 PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, SURVEYS, PROCESSING OF CLAIMS, FINANCIAL AUDIT, OR TO PERFORM INTERNAL ADMINISTRATIVE FUNCTIONS. I UNDERSTAND THAT THE TRUST FUND, ITS AGENTS OR EMPLOYEES, MAY NEED TO DISCLOSE MY CONFIDENTIAL INFORMATION TO OTHERS. ANY SUCH DISCLOSURE SHALL BE MADE 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.

ARBITRATION: I AGREE THAT ANY DISPUTE OR CONTROVERSY WHICH MAY ARISE BETWEEN MYSELF OR ANY FAMILY MEMBER AND A PREPAID PLAN OR HEALTH MAINTENANCE ORGANIZATION (HMO), OR ANY OF ITS PROVIDERS, SHALL BE SETTLED BY THE PREPAID PLAN'S OR HMO'S FINAL AND BINDING ARBITRATION RULES, IF ANY.

SPOUSE/ DOMESTIC PARTNER'S CONSENT TO DISCLOSURE OF SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION BY MY SIGNATURE BELOW, I AUTHORIZE THE TRUST FUND TO OBTAIN MY SOCIAL SECURITY RECORDS AND BENEFIT INFORMATION FROM MY EMPLOYERS FOR PURPOSES OF DETERMINING MY ELIGIBILITY AS A SPOUSE UNDER THE PLAN.

SIGNATURE REQUIRED: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM, WHICH I HAVE FULLY READ AND UNDERSTAND.

Participant's Signature: _____ Date: _____
 Spouse's Signature: _____ Date: _____
 OR
 Domestic Partner Signature: _____ Date: _____