**Bakers Union and FELRA**
**Health and Welfare Fund**

911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (410) 683-6500
Toll Free: (866) 662-2537
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, MD 20785-2361
Telephone: (301) 459-3020
Toll Free: (866) 662-2537
www.associated-admin.com

## ENROLLMENT FORM

**Participant (Employee) Information**

| Last Name | First Name | MI | **OFFICE USE ONLY** Effective | Terminated |
|---|---|---|---|---|
| Address | | Local Union # | A. | |
| | | | B. | |
| City: | State | 9-digit Zip Code | C. | |
| Telephone: | Sex: M/F | Date Employed: | Date of Birth: | |
| Your Social Security Number | Company, Job Classification | | | |

Marital Status: Married Single Widowed Divorced Separated

Date of Marriage:

Coverage Desired: Individual Parent/Child Husband/Wife Family

Name of any other health insurance covering you including Medicare
Name of Insured: Type of Insurance:

Policy Number: Name of Insurance: Employer:

Name of any other health insurance covering your dependent(s), including Medicare
Name of Insured: Type of Insurance:

Policy Number: Name of Insurance: Employer:

Death Benefits to be paid to [Name/Relationship]:
Beneficiary's Address:

MAIL COMPLETED ENROLLMENT FORM AND ALL REQUIRED INFORMATION TO:
**BAKERS UNION AND FELRA HEALTH & WELFARE FUND**
**911 Ridgebrook Road**
**Sparks, MD 21152**
**(866) 662-2537**

**IMPORTANT NOTICE: IF YOU ARE ENROLLING A SPOUSE OR DEPENDENT CHILD(REN), A COPY OF YOUR MARRIAGE LICENSE AND/OR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS COMPLETED ENROLLMENT FORM IN ORDER TO BE ELIGIBLE FOR COVERAGE.**

## LIST THE NAME(S) OF YOUR DEPENDENT CHILDREN UP TO AGE 26 AND YOUR SPOUSE FOR WHOM YOU DESIRE COVERAGE

| DEPENDENTS – ELDEST FIRST | RELATIONSHIP | DATE OF BIRTH | [1]SOCIAL SECURITY NUMBER | CERTIFICATION OF OTHER HEALTH COVERAGE |
|---|---|---|---|---|
| | | | | ☐ I hereby certify that the dependent shown in this row **does not** currently have other insurance.<br>☐ I hereby certify that the dependent shown in this row does have other health insurance and I have listed insurance provider on the previous page. |
| | | | | ☐ I hereby certify that the dependent shown in this row **does not** currently have other insurance.<br>☐ I hereby certify that the dependent shown in this row does have other health insurance and I have listed insurance provider on the previous page. |
| | | | | ☐ I hereby certify that the dependent shown in this row **does not** currently have other insurance.<br>☐ I hereby certify that the dependent shown in this row does have other health insurance and I have listed insurance provider on the previous page. |
| | | | | ☐ I hereby certify that the dependent shown in this row **does not** currently have other insurance.<br>☐ I hereby certify that the dependent shown in this row does have other health insurance and I have listed insurance provider on the previous page. |

☐ I hereby apply for participation for my dependent(s), subject to the Fund's eligibility rules, in the Bakers Union and FELRA Health and Welfare Trust Fund. I understand that I, the Participant, must be enrolled as well and that this application is subject to me being employed by a Participating Employer and covered by a collective bargaining agreement with a Participating Union. I and my eligible dependent(s) agree to follow the rules and regulations determined by the Board of Trustees as communicated to me through the Bakers Union and FELRA Health and Welfare Trust Fund's Summary Plan Description and updates thereto. I understand that if my above listed dependent(s) becomes eligible for other employer-based coverage, I will immediately notify the Fund Office concerning that eligibility.

**I certify that I have carefully read both sides of the enrollment form and agree to the terms specified thereon. The foregoing statements are complete, true and correctly recorded.**

Participant's Signature (DO NOT PRINT): ____________________________________________ Date: ______________________

Dependent's Signature (DO NOT PRINT): ____________________________________________ Date: ______________________

Dependent's Signature (DO NOT PRINT): ____________________________________________ Date: ______________________

Dependent's Signature (DO NOT PRINT): ____________________________________________ Date: ______________________

[1]Social Security Numbers are required for all eligible dependents in order to receive benefits.

**FALSIFICATION OF INFORMATION MAY CAUSE A SUSPENSION OF BENEFITS FOR YOU AND YOUR DEPENDENT(S)**

*Bakers/FELRA Enrollment Form/rp 09.2017*