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
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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:			

THIS IS NOT AN APPLICATION FOR DENTAL INSURANCE
PLEASE READ BOTH SIDES OF THIS FORM CAREFULLY

The Board of Trustees of the Bakers Union and FELRA Health and Welfare Trust Fund believe the plan is a **"grandfathered health plan"** under the Patient Protection Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections in the Affordable Care Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the plan administrator by contacting the Fund Office in writing at, 911 Ridgebrook Road, Sparks, MD 21152. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or through its website www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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(S) UP TO AGE 26 FOR WHOM YOU DESIRE COVERAGE

DEPENDENTS – ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	[1]SOCIAL SECURITY NUMBER	CERTIFICATION OF NO EMPLOYMENT-BASED HEALTH COVERAGE
[2]In order for your dependent(s) age 19-26 to qualify for coverage, you and your dependent(s) must certify below that the dependent is not eligible for (i.e., does not have the ability to obtain) other health coverage through his/her own employer and, if married, through his/her spouse's employer.				
				☐ I hereby certify that the dependent shown in this row is not currently employed. ☐ I hereby certify that this dependent is employed but is not eligible for health coverage through his/her employer (and if married is not eligible for health coverage through his/her spouse's employer).
				☐ I hereby certify that the dependent shown in this row is not currently employed. ☐ I hereby certify that this dependent is employed but is not eligible for health coverage through his/her employer (and if married is not eligible for health coverage through his/her spouse's employer).
				☐ I hereby certify that the dependent shown in this row is not currently employed. ☐ I hereby certify that this dependent is employed but is not eligible for health coverage through his/her employer (and if married is not eligible for health coverage through his/her spouse's employer).
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				☐ I hereby certify that the dependent shown in this row is not currently employed. ☐ I hereby certify that this dependent is employed but is not eligible for health coverage through his/her employer (and if married is not eligible for health coverage through his/her spouse's employer).

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: ______________

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[1] Social Security Numbers are required for all eligible dependents in order to receive benefits.
[2] Your dependent between age 19-26 does not actually have to enroll in other employment-based health coverage to be ineligible for coverage under the Fund. If your dependent is or becomes eligible to enroll in his or her own employment-based health coverage, or employment-based coverage through his/her spouse, he/she is not eligible for coverage under the Fund.

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