UFCW LOCAL 1500 WELFARE FUND FULL-TIME PLAN
SPOUSAL ENROLLMENT INFORMATION

Member's Name:_____

Member's Social Security Number:_____

Member's Date of Birth:_____

Member's Address:_____

Spouse's Name:_____

Spouse's Date of Birth:_____

Spouse's Social Security Number:_____

Spouse's Address, if different than yours:_____

Spouse's Employer:_____

Spouse's Employer Address:_____

Spouse's Employer Phone Number:_____

Year(s) Employed at Above Employer:_____

Is Health Coverage available through Spouse's Employer? Yes or No
(Please circle applicable answer)

If yes, type of Coverage provided: Individual or Family (Please circle applicable answer)

Is your Spouse eligible for Coverage under his/her Employer's Health Plan? Yes or No
(Please circle applicable answer)

If no, please explain in the comments section on next page.

If no, was a waiver signed by your Spouse to Opt-Out of his/her Employers Health Plan? Yes or No
(Please circle applicable answer)

If no, was your Spouse reimbursed for choosing not to be covered under his/her Employer's Health Plan? Yes or No (Please circle applicable answer)

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Is Spouse covered under Employer's Health Plan? Yes or No
(Please circle applicable answer)

If so, Name of Insurance Company or Coverage:_____

Policy #:_____

Effective Date of Coverage in Employer Health Coverage?_____

Is there an Enrollment Period to participate in your Spouse's Employer's Health Plan? Yes or No
(Please circle applicable answer)

If yes, next enrollment Period: From:_____ To:_____; Effective Date of Coverage:_____

What type of Coverage is provided to your Spouse by his/her Employer? Please note all applicable benefits:

COVERAGE	YES	NO	COVERAGE	YES	NO
Hospital			Dental		
Medical			Optical		
Prescription Drug					

COMMENTS:_____

IMPORTANT NOTICE: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY/HEALTH FUND OR OTHER PERSON, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT OR MATERIAL COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

I, _____, state that I have read the above and I understand the information.
Print Member's Name

I further state that I personally completed this form and all information is complete and accurate.

Member's Signature:_____

Date:_____

RETURN FORM TO:
UFCW Local 150 Welfare Fund
Attn: Medical Department
425 Merrick Avenue
Westbury, NY 11590