United Food and Commercial Workers Unions
and Participating Employers
Health and Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

APPLICATION/PAYROLL DEDUCTION AUTHORIZATION FOR FUND COVERAGE
PLAN Y20 PART TIME

(**Print**) Employee's Name: _____ Social Security # _____

Employee's Address: _____ Email Address: _____

_____

_____

Employee's Phone #: _____

I authorize my employer to deduct the co-payment amount selected below from my earnings. Coverage will remain in effect until December 31st unless a life event occurs such as adding a new child. Otherwise, changes can be made at open enrollment. ***Per Fund rules, any other group coverage will be primary to this Fund's coverage, even if offered and not taken.***

[ ] Individual coverage for myself -- $5.00/Week
[ ] $127.81 per month *for* ***each*** *dependent child* in addition to the $5/week for your own coverage. This amount is subject to change in 2018. If it does, you will be notified and given an opportunity to drop or continue coverage on your dependent child(ren).
[ ] I am not electing coverage at this time.

If you are adding dependent coverage, be sure to send the necessary forms of documentation (copy of birth certificate, etc.)

Signature_____ Date _____

Please keep a copy of this form for your records.

Return Forms to: Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
Fax: (410) 683-7792
Email to: enroll@associated-admin.com

If you email forms, please only use the last 4 digits of your Social Security Number to ensure privacy.