UFCW UNIONS & PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

APPLICATION/PAYROLL DEDUCTION AUTHORIZATION FOR FUND COVERAGE
Plan Y Full Time, Plan Y20 Full Time, and JSS2 Participants (FT and PT)

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

Employee's Address: _____

_____

_____

Employee's Phone #: _____ Email Address: _____

All Shoppers participants are required to pay a small portion of the cost of health coverage through the Fund via payroll roll deduction. The cost for this coverage is shown below.

I authorize my employer to deduct the co-payment amount selected below from my earnings. Coverage will remain in effect through December 31, 2018 unless a life event occurs such as adding a child or a spouse. Otherwise, changes can be made at open enrollment.

[ ] Individual Only Coverage - **$5.00/Week**
[ ] Participant Plus One Dependent -- **$10.00/Week**
[ ] Participant Plus Two or More Dependents -- **$15.00/Week**
[ ] I am not electing coverage at this time.

SPECIAL NOTE FOR KAISER PARTICIPANTS
If you pay a monthly premium to be enrolled in Kaiser, that will continue ***in addition*** to the payroll deduction above.

If you are adding a spouse, be sure to read and complete the enclosed Spousal Surcharge form.

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.