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 Y30 PART TIME

(**Print)** Employee's Name: _____ Last 4 digits of SSN: _____

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 -- $10.00/Week

[ ] $125.54 per month *for **each** dependent child* in addition to the $10/week for your own coverage. This amount is subject to change in 2018.

[ ] 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.