**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

## PLAN Y20 PART TIME ENROLLMENT FORM – COVERAGE TO AGE 26

**Name of Employee**

| Last Name | First Name | MI | **OFFICE USE ONLY** Effective | Terminated |
|---|---|---|---|---|
| Address | | | A. | |
| | | | B. | |
| City | State | Zip Code | C. | |
| Telephone | Sex: M/F | Date Employed | Date of Birth | |
| Your Social Security No. | Company, Job Classification | Weekly Hours | | |
| Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated<br>Date of Marriage: | | | | |
| Coverage Desired : ☐ Individual ☐ Parent/Child ☐ Family | | | | |
| If other coverage was declined on your or any dependent, did you receive cash or benefit dollars for declining?<br>☐ Yes ☐ No If yes, please attach explanation. | | | | |
| Death Benefits to be paid to (Name/Relationship):<br>Beneficiary's Address | | | | |
| Date Signed | Signature | | | |

**THIS IS NOT AN APPLICATION FOR DENTAL INSURANCE.**

**PLEASE READ BOTH SIDES OF FORM CAREFULLY**

I hereby apply for participation in the UFCW Unions and Participating Employers Health & Welfare Fund. I understand 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 agree to follow the rules and regulations as determined by the Board of Trustees as communicated to me in my Summary Plan Description or updates thereto.

I further agree that any physician, hospital or other provider of service that has made a diagnosis, rendered treatment or provided service in connection with any illness for which hospital, medical or other health care benefit is sought under this participation is authorized to furnish you, upon request, full information and records or copies relating to the diagnosis, treatment, or care rendered. Such information shall be held confidential.

I certify that I have carefully read both sides of this enrollment form and agree to the terms specified thereon. The foregoing statements are complete, true, and correctly recorded.

Date_____ Signature (DO NOT Print)_____

MAIL COMPLETED FORM TO:

**UFCW UNIONS & PARTICIPATING EMPLOYERS HEALTH & WELFARE FUND**
**911 Ridgebrook Road, Sparks, MD 21152**
**(410) 683-6500 or (800) 638-2972**

**(over)**

I understand that as a part time employee of a participating employer covered by a collective bargaining agreement with a participating union, I can elect health care benefits for my dependents by making appropriate co-payments. I also understand that the Administrative Manager must receive my application at least 60 days before the date coverage is to begin. If I do not enroll my dependents when first eligible, enrollment will thereafter be restricted to the open enrollment of the next calendar year. The effective date of dependent coverage is determined by the collective bargaining agreement.

I authorize my employer above to deduct from my earnings the co-payment amount determined by the Fund to provide dependent coverage. I may cancel this coverage by contacting the Fund office in writing at least 30 days in advance of the date I would like coverage to cease. Cancellation of this authorization will terminate my eligibility for dependent coverage and I understand I may not reapply for dependent coverage until the open enrollment period following 12 full months from the date the cancellation takes effect.

**Individual Coverage: $5 per week (payable via payroll deduction)**
**Dependent Child Coverage:**

- **$127.81 per month for one child**
- **$255.62 per month for two children**
- **$383.43 per month for 3 or more children**

**The charge for dependent child coverage is in additional to your weekly $5 co-payment.**

Date: _____ Signature (DO NOT PRINT): _____

**LIST BELOW NAMES OF YOUR UNMARRIED CHILDREN UNDER 26 YEARS OF AGE WHO ARE TOTALLY DEPENDENT ON YOU.**

| LIST NAMES IN ORDER OF AGE – ELDEST FIRST | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**A COPY OF YOUR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS APPLICATION.**

Name any other health insurance covering your dependent(s), including Medicare:

**Name: _____ Policy No.: _____**

**SPECIAL ENROLLMENT PROVISIONS**

**If you turned down coverage for either yourself or for your dependents** because you were covered under another group plan, and then that other coverage ends, you may be able to enroll yourself and your dependents under the Fund, **provided you do so within 30 days from the date your other coverage ended**. However, there are only a limited number of circumstances when you can enroll when you lose coverage. If the other coverage was COBRA coverage, you may request enrollment under this Fund only if the COBRA coverage is exhausted. For other group coverage, you may request enrollment under this Fund if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased. You are not eligible to enroll under this provision if the other coverage was lost because you stopped paying premiums.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days from the date of marriage, birth, adoption or placement for adoption.

**CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009**

Effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"). However, to do so, you must request enrollment within 60 days of the date that CHIP of Medicaid assistance is terminated for you or your dependents.

In addition, effective April 1, 2009, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. However, to do so, you must request enrollment within 60 days of the date you or your dependents are determined to be eligible for the premium assistance through Medicaid or CHIP.

To request special enrollment or to obtain more information, contact the Fund office at (800) 638-2972 and ask for the Eligibility Department.