

**UFCW Unions & Participating Employers  
Retiree Health and Welfare Plan**

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

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

November 2015

Dear Shoppers Medicare-Eligible Retiree:

As a result of collective bargaining, effective January 1, 2016, you will be required to make a monthly co-payment in order to maintain your retiree health and welfare benefits (including medical, prescription drug, optical and dental) through the Fund. **The co-payment will be \$20 per month for individual coverage, \$40 per month for individual plus one, and \$60 per month for family coverage which includes the Medicare-Eligible retiree and two or more dependents.**

This co-payment will be deducted from your pension each month unless you notify the Fund Office that you prefer to pay by check. If you choose to pay by check, the payment is due on the 25<sup>th</sup> of the month **preceding** the month for which coverage is desired (for example, March's payment would be due on February 25<sup>th</sup>).

Please complete the next page and return to the Fund Office to indicate your approval for the co-payment to be deducted from your pension each month. **If you do not make this monthly co-payment, your retiree health and welfare benefits will terminate December 31, 2015.** If you have questions, please contact the Fund office.

Sincerely,

Fund Office

**Please fill out this form and return to:**

**MAIL**

Fund Office  
911 Ridgebrook Road  
Sparks, Maryland 21152-9451  
Attn: Shoppers/SuperValu

**E-MAIL**

[enroll@associated-admin.com](mailto:enroll@associated-admin.com)

**FAX**

1-800-418-1545

I approve the monthly deduction from my pension for retiree co-payments in the amount of:

\$20 (individual coverage)

\$40 (individual plus one dependent)

\$60 (individual plus two or more dependents)

I choose to have my coverage end 12/31/2015

\_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Last 4 digits of Social Security Number