UFCW & Employers Arizona Health and Welfare Trust

2400 W. Dunlap Ave., Suite 250, Phoenix, AZ 85021
Phone (602) 249-3582 Toll Free (800) 474-3485 Fax (602) 249-3795

ENROLLMENT FORM

This form must be completed fully upon **ENTRY** into the plan, **AND** it may also be used to submit any updated information throughout the year.
✓ ***Entry Verifications*** **- IMPORTANT - DO NOT DELAY**. Before benefits for you and your family can be paid, your form must be sent to the fund office **-fully completed**, signed and dated by you. Without this information, the fund office **cannot** certify **benefits** to doctors, hospitals, labs, pharmacies or any other health care provider. DO NOT WAIT UNTIL A FAMILY MEMBER NEEDS HEALTH CARE. SEND YOUR COMPLETED FORM TO THE FUND OFFICE ***NOW.***
✓ ***To update information*** - Complete the Employee Information section and sections that show the change you are reporting, and send to the Fund office.

CHECK ONE: ☐ **NEW EMPLOYEE** ☐ **ADD SPOUSE, NEWBORN/CHILD** ☐ **CHANGE PERSONAL DATA**

EMPLOYEE INFORMATION

1. LAST NAME:	FIRST NAME:	MI:	☐ M ☐ F	2. BIRTH DATE / /	3. SOCIAL SECURITY # / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS	CITY	STATE	ZIP	5. PHONE NUMBER ( ) -	6. EMPLOYER

SPOUSE INFORMATION

7. LAST NAME:	FIRST NAME:	MI:	8. BIRTH DATE / /	9. SOCIAL SECURITY # / /
10. IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES			IF YES - EMPLOYER:	

SPOUSE OTHER INSURANCE INFORMATION

11. DOES YOUR SPOUSE'S EMPLOYER OFFER A GROUP HEALTH PLAN? ☐ YES ☐ NO (IF "NO", SKIP TO #12) GROUP OR I.D. NUMBER _____

IF YES, IS YOUR SPOUSE ENROLLED IN HIS/HER EMPLOYERS HEALTH PLAN? ☐ YES ☐ NO PLEASE INDICATE TYPE OF COVERAGE: ☐ MEDICAL, ☐ DENTAL, ☐ VISION

EFFECTIVE DATE OF COVERAGE: _____ / _____ / _____, NAME OF INSURANCE COMPANY _____

MEDICARE? ☐ YES ☐ NO **(IF MEDICARE ELIGIBLE ATTACH A COPY OF THE MEDICARE CARD)** HICN HUMBER _____

12. IF NO - WHY NOT? ☐ NOT ELIGIBLE UNTIL _____ / _____ / _____, ☐ OTHER - EXPLAIN _____

NOTE: IF YOUR SPOUSE IS ELIGIBLE FOR **MEDICAL** BENEFITS UNDER HIS/HER EMPLOYER'S PLAN, THIS PLAN WILL TAKE CREDIT FOR THAT COVERAGE WHETHER YOUR SPOUSE HAS ENROLLED IN IT OR NOT.

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION FOR A FULL EXPLANATION.

13. DEPENDENT CHILDREN INFORMATION

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	SEX	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE
	/ /	☐ M ☐ F	/ /	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER, SPECIFY:
	/ /	☐ M ☐ F	/ /	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER, SPECIFY:
	/ /	☐ M ☐ F	/ /	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER, SPECIFY:
	/ /	☐ M ☐ F	/ /	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER, SPECIFY:
	/ /	☐ M ☐ F	/ /	☐ NATURAL CHILD ☐ STEP CHILD ☐ OTHER, SPECIFY:

NOTE: YOU MUST ATTACH A BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS. YOU MUST ATTACH A COPY OF A SCHOOL CERTIFICATE OF ENROLLMENT FORM FOR ANY DEPENDENT CHILD STUDENT AGE 19 TO 23.

14. DEPENDENT OTHER INSURANCE INFORMATION

IS DEPENDENT COVERED BY ANOTHER PLAN? ☐ YES ☐ NO MEDICARE? ☐ YES ☐ NO IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD	IF YES - SHOW NAME OF COVERED EMPLOYEE: EFFECTIVE DATE OF COVERAGE: NAME OF OTHER PLAN:	SOCIAL SECURITY # / /
IF YES, PLEASE INDICATE TYPE OF COVERAGE: ☐ MEDICAL, ☐ DENTAL, ☐ VISION	ADDRESS:	GROUP, I.D. OR HICN NUMBER:

15. NOTICE OF CHANGE: ☐ **ADD DEPENDENT(S)** ☐ **DELETE DEPENDENT(S)**

MARRIAGE ☐ DIVORCE ☐ OTHER ☐	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
	IF OTHER - PLEASE EXPLAIN:			
MARRIAGE ☐ DIVORCE ☐ OTHER ☐	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
	IF OTHER - PLEASE EXPLAIN:			

NOTE: YOU MUST ATTACH A COPY OF THE MARRIAGE CERTIFICATE OR DIVORCE DECREE

16. FRAUD NOTICE

I UNDERSTAND THAT THE TRUST FUND IS RELYING ON MY ANSWERS ON THIS FORM. I REPRESENT, UNDER PENALTY OF PERJURY, THAT THE ANSWERS GIVEN TO ALL QUESTIONS ON THIS FORM ARE TRUE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY AND WITH INTENT TO DEFRAUD THE TRUST FUND, PROVIDE MATERIALLY FALSE INFORMATION OR CONCEAL, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, I MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. I UNDERSTAND THAT IT IS A FEDERAL CRIME, PUNISHABLE BY FINE OR IMPRISONMENT, OR BOTH, TO KNOWINGLY MAKE FALSE STATEMENTS ON THIS VERIFICATION FORM.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF ARIZONA THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND I CONSENT TO THE PROVISIONS STATED ABOVE ON THIS FORM WHICH I HAVE FULLY READ AND UNDERSTAND.

17. AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CLAIM. I WILL REIMBURSE THE FUND FOR ANY OVERPAYMENT MADE TO ME OR I MY BEHALF DUE TO ERROR ON THIS FORM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER, FOR HIS SERVICES AS DESCRIBED HEREON, OR IN SUPPLEMENTAL STATEMENT, NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN FORCE UNTIL CANCELLED IN WRITING BY ME

	/ /	/ /
EMPLOYEE'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE