

*UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS
Arizona Health & Welfare Trust*

ADMINISTRATOR: Southwest Service Administrators, Inc.
2400 W. Dunlap Ave., Suite 250 • Phoenix, AZ 85021 • Phone 602-249-3582 • Toll Free 1-800-474-3485 • Fax 602-249-3795

RETIREE MEDICAL PLAN ENROLLMENT APPLICATION

1. NAME _____
First _____ Middle _____ Last _____
2. S.S. NO. _____ 3. PHONE NO (_____) _____
4. ADDRESS _____
City _____ State _____ Zip _____
5. DATE OF BIRTH _____ 6. PENSION EFF DATE _____ AGE _____
7. Were you an active participant in the Arizona Welfare Fund for 12 out of the last 24 months preceding your retirement date?
YES NO Last Day Worked Was _____
- Name of Last Employer _____
8. Have you applied for pension benefits? YES NO
9. Name of pension plan: Desert States Employers & UFCW Unions Pension Plan
 UFCW International Union – Industry Pension Fund (National Pension Fund)
PLEASE SEND A COPY OF YOUR AWARD LETTER
10. Are you eligible for Medicare benefits? YES NO
11. Are you eligible to receive Social Security Disability Benefits?
YES What is your award date? _____ NO
(If yes, please send copy of your Award Letter)

NOTE: COMPLETE THIS SECTION ONLY IF YOU WISH TO ALSO ENROLL YOUR ELIGIBLE SPOUSE

12. SPOUSE'S NAME _____
13. S.S. NO. _____ 14. DATE OF BIRTH _____
15. Is your spouse eligible for Medicare benefits? YES NO
16. Is your spouse eligible to receive Social Security Disability Benefits?
YES What is the award date? _____ NO
(If yes, please send copy of the Award Letter)

I hereby elect to enroll in the Retiree Medical Plan at the current contribution rate of \$225.00 per month per person and authorize Desert States to deduct the monthly contribution to be automatically transferred to UFCW, as follows:

CHECK ONE OR BOTH, AS APPROPRIATE FOR MYSELF FOR MY SPOUSE
My initial payment of \$ _____ (at \$225.00 per month per person) is enclosed.

If my monthly health coverage premium under the Health Plan exceeds the amount of my monthly pension benefit under the Pension Plan, I will no longer be eligible for the automatic transfer option and will have to mail in my monthly premium.

PLEASE MAKE CHECK PAYABLE TO: UFCW & Employers Arizona Health & Welfare Trust

I understand that my eligibility and/or my spouse's eligibility for participation in this plan will end when we become eligible for any type of Medicare. I also understand that the Board of Trustees may be required to adjust this monthly contribution rate from time to time.

Signature

Date