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 Inquiry

Dear Retiree Applicant,

Our records indicate you are inquiring/applying for Pension Benefits and are interested in continuing medical coverage under the Retiree Plan. In order to determine if you qualify for this Plan you must complete a Medical Plan Enrollment form. The basic criteria for acceptance into the plan are:

- Is NOT eligible for Medicare
- Is retired
- Is eligible to receive pension benefits from and has **at least 15 years of vesting credit** under the pension plan in which participation is required by a Collective Bargaining Agreement with UFCW Local 99 or in service to the Fund.
- Was covered under plan 501-A or 501-B for at least 12 of the last 24 months including the month immediately preceding retirement

Please note, receipt of this letter or completion of an enrollment form does not guarantee acceptance into the Plan.

It is highly recommended you review the SPD (Summary of Plan Details) to understand benefits available to you and your Spouse should you qualify. If you have any questions on your Retiree benefits, please contact Customer Service at (602) 249-3582 or if outside Arizona, toll-free at (800) 474-3485.

If you are interested in participating, complete the attached application and return it in the enclosed UFCW envelope.

Thank you,

The Trust Fund Office

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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: ____________________

   Name of Last Employer ______________________________________
8. Have you applied for pension benefits? YES ☐ NO ☐
9. Do you have 15 years of vesting credit? YES ☐ NO ☐ Not Sure ☐
10. 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
11. Are you eligible for Medicare benefits?
    YES ☐
    NO ☐
12. 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

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

I hereby elect to enroll in the Retiree Medical Plan at the current contribution rate of $275.00 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 $275.00 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 in this plan will end** when we become eligible for any type of Medicare and **I am responsible to notify the Fund office** immediately when we become Medicare Eligible. I also understand that the Board of Trustees may be required to adjust this monthly contribution rate from time to time.

______________________________ ______________________________
Signature   Date

Revised:6/8/2011