

UNITED FOOD & COMMERCIAL WORKERS & EMPLOYERS AZ HEALTH FUND

DATE: _____

RE: ENROLLMENT FOR HEALTH & WELFARE COVERAGE
RESPONSE REQUIRED BY ****

Dear New Employee:

Please complete the enclosed enrollment form and mail it back in the return envelope no later than ****
_____.

Once received and processed, your health insurance coverage will begin on _____**** as long as you work the number of hours required in your collective bargaining agreement.

For your information, the weekly deduction for the PrePaid Deductible and Coinsurance account is as follows:

Employee Only	Employee Plus Child or Children	Full Family (Spouse + Children)
\$2.50 Per Week	\$10 Per Week	\$15 Per Week

Once you make an election, you cannot change that election until the next Open Enrollment period (October) for the following year's coverage. The only exception is when a "Life Event" occurs---marriage, divorce, births, adoptions, foster children placement or other loss of coverage.

You can find a complete list of your benefits, forms and other information about Plan B1 by going to www.southwestservicetpa.com and clicking on UFCW & Employers AZ Health Fund on the left side of the page. Once you enroll in the Health Plan, ID cards and other materials will be mailed to your home address.

If you have any questions, please call your Health Plan office at the numbers shown at the bottom. Spanish speaking representatives are available.

Sincerely,

HEALTH PLAN OFFICE

**UNITED FOOD & COMMERCIAL WORKERS
& EMPLOYERS AZ HEALTH & WELFARE TRUST**
2400 West Dunlap Avenue, Suite 250, Phoenix, AZ 85021
Toll Free: (800) 474-3485 Phone: (602) 249-3582 Fax: (602) 249-3795
www.southwestservicetpa.com

ENROLLMENT FORM – PLAN B1

Instructions: This form must be completed fully upon entry into the plan. Changes to your or your dependent coverage may only be made during open enrollment. The only exception to this rule is in the case of certain qualifying events such as marriage, divorce, death, birth, adoption or placement for adoption or loss of health coverage. All changes made due to a qualifying event must be submitted within thirty days of the qualifying event or any enrollment activity will take place during the next open enrollment.

1.) Purpose for completing this form						
<input type="checkbox"/> Open Enrollment		<input type="checkbox"/> New Employee		<input type="checkbox"/> Adding Dependents		
<input type="checkbox"/> Name Change (include documentation)		<input type="checkbox"/> Address Change		<input type="checkbox"/> Other _____		
2.) Payroll Deduction Authorization						
<input type="checkbox"/> I authorize my employer _____ to deduct from my weekly payroll for coverage as indicated below at the established amount set by <small>(Name of Employer)</small> the Collective Bargaining Agreement. (Select A or B)						
A.) <input type="checkbox"/> \$2.50 Employee Only <u>OR</u> B.) <input type="checkbox"/> \$10 Employee Plus Children						
SPECIAL NOTE FOR MARRIED EMPLOYEES: If you are married when (or after) you become eligible, your spouse will be eligible for coverage 12 months <i>after your (the Employee's) eligibility begins</i> ; if you want your spouse to be covered at that time we will notify your employer to begin the \$15 deduction <i>when your spouse is eligible</i> . Please check here <input type="checkbox"/> to authorize this change in your deduction.						
3.) Employee Information						
Last Name		First Name		MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date / /
Address			City	ST	Zip	Phone () -
Social Security Number		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include copy of card		
Email Address:						
4.) Spouse Information						
You must attach a copy of your marriage certificate and divorce decree if applicable and if you have not already done so. Eligibility for your spouse shall be subject to all provisions and limitations of the Trust Agreement and Plan Document as well as to any rules and regulations adopted by the Board of Trustees. Please see your summary plan description for a full explanation.						
Last Name		First Name		MI	Social Security Number / /	Birth Date / /
Date of Marriage	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name and Address		Employers Phone () -		Coverage Type <input type="checkbox"/> Family <input type="checkbox"/> Single
What coverage does your spouse's employer provide? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> RX <input type="checkbox"/> None (check all that apply)			Was the coverage accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other _____		Medicare Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes include copy of card	
Name of Insurance	Insurance Address		ID Number	Effective Date	Insurance Phone () -	

5.) Dependent Children Information

You must include a copy of the certified birth certificate for all newly added children. Social Security Numbers are required for all dependents. You must also include the Adult Dependent Certification Form for any dependent children age 19 to 26 (the form is available via our website at www.southwestservicetpa.com). 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 and regulations adopted by the Board of Trustees. Please see your summary plan description for a full explanation of Covered Dependents.

Full Name (Last, First, MI)	Sex	Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship to employee
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other _____
Are any dependents covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Eligible? <input type="checkbox"/> Yes (include copy of card) <input type="checkbox"/> No		Indicate type of coverage (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> RX <input type="checkbox"/> None	
Name of policy holder	Social Security Number / ID Number		Effective Date of coverage	
	/ /			
Name of plan	Address		Phone () -	

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 claims. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form. I hereby authorize payment directly to the provider for services rendered in accordance with the terms of the Plan. 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.

Fraud Notice

I understand that the Fund is relying on my answers on this form. I declare, 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, provide false information or conceal information concerning any material fact for the purpose of misleading the Fund 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.

Print Your Name Here

Sign Your Name Here

DATE