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

– IMPORTANT NOTICE –

NEW MEDICARE REQUIREMENTS FOR SOCIAL SECURITY AND MEDICARE HICN NUMBERS

TO: ALL PLAN PARTICIPANTS

FROM: TRUST FUND OFFICE

******* ENROLLMENT FORM FOR FAMILY SOCIAL SECURITY NUMBERS *******

New federal regulations require that your health plan gather and report social security numbers to Medicare beginning this year. The reason that Medicare requires this information is so they don't pay as the primary payor when your health plan should pay first. Significant penalties will apply if this information is not provided to Medicare.

In order to gather this information, please complete the attached enrollment form and return it to the Fund Office in the enclosed, return envelope by March 30, 2009. It is imperative that you provide the social security numbers for all family members. You must also provide Medicare's HICN number if you or any of your family members are eligible for Medicare. A copy of the Medicare ID card will suffice.

Failure to provide this information may result in benefit and eligibility termination for your dependents.

Although the enrollment form asks that you submit copies of birth and marriage certificates and/or divorce decrees, you **DO NOT NEED** to submit these documents **IF YOU HAVE ALREADY PROVIDED** that information to the Fund Office.

The purpose for this enrollment form is to gather social security/Medicare HICN numbers for your family. Please complete those sections of the enrollment form carefully and be sure to sign and date the form.

For information regarding Medicare's reporting regulations, you can read the text at:

https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf

Thank you for your cooperation. Please call our Customer Service Department if you have any questions.

Sincerely,

TRUST FUND OFFICE
March 2009

– AVISO IMPORTANTE –

NUEVOS REQUISITOS DE MEDICARE PARA EL SEGURO SOCIAL Y LOS NUMEROS DE HICN DE MEDICARE

PARA: TODOS LOS PARTICIPANTES DEL PLAN

DEPARTE DE: OFICINA DEL FONDO DE FIDUCIARIOS

****** FORMA DE INSCRIPCIÓN PARA LOS NÚMEROS DE SEGURO SOCIAL DE LA FAMILIA ******

Recientes reglamentos federales exigen que su plan de salud colecte e informe a Medicare los números de seguro social a partir de este año. La razón por la que Medicare requiere esta información es para que no paguen como aseguranza primaria, cuando su plan de salud debe pagar primero. Importantes sanciones se aplicarán si no se facilita esta información a Medicare.

Con el fin de recoger esta información, favor de completar la forma de inscripción adjunta y envíela a la Oficina del Fondo en el sobre de retorno proporcionado no mas tarde de Marzo 30, 2009. Es imperativo que usted provea el número de seguridad social para todos los miembros de la familia. También debe proporcionar el número HICN de Medicare si usted o cualquiera de los miembros de su familia son elegibles para Medicare. Una copia de la tarjeta de identificación de Medicare será suficiente.

No proporcionar esta información puede resultar en la terminación de los beneficios y elegibilidad para sus dependientes.

Aunque la forma de inscripción pide que envíe copias de los certificados de nacimiento, de matrimonio y / o divorcio, **NO ES NECESARIO** presentar estos documentos **SI YA HAN PROPORCIONADO** esa información a la Oficina de Fondo.

El propósito de esta forma de inscripción es de colectar los números de seguro social / números HICN de Medicare para su familia. Por favor, complete las secciones de la forma de inscripción con cuidado y asegúrese de firmar y fechar la forma.

Para obtener información sobre la presentacion regulatoria de Medicare, puede leer el texto en:

https://www.cms.hhs.gov/MandatoryInsRep/Downloads/SupportingStatement082808.pdf

Gracias por su cooperación. Por favor llame a nuestro Departamento de Servicio si tiene alguna pregunta.

Atentamente,

Oficina de Fondo
Marzo 2009

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 IN 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