

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

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



United Food and Commercial Workers & Employers Arizona Health & Welfare Trust

Dear Participant:

In March of this year, you were sent a letter describing Medicare's new regulations that requires all health plans to report the social security numbers of ALL eligible family members to Medicare. Significant penalties apply to health plans that do not comply with Medicare's social security number requirements.

As of today, our records show that you have not provided the social security numbers of your dependents.

Another enrollment form is enclosed. Please complete it and return it promptly in the enclosed return envelope. Unless we receive your completed form by November 15th, **eligibility for you and your dependents may not be available beginning January 1, 2010 until the information is received.**

PLEASE NOTE: For any employee or family member that is eligible for Medicare, we MUST HAVE THE MEDICARE ID number also or simply send us a copy of the Medicare ID card, if you prefer.

We understand that some of you may be wary about giving out your family's social security numbers and we understand your concerns. Southwest Service Administrators follows all government standards when it comes to protecting your private information and, for your information, the social security number data sent to Medicare will be done so in a government approved, secured and encrypted format.

To read more on Medicare's requirements, go to www.cms.hhs.gov/MandatoryInsRep.

Thank you for your cooperation.

Sincerely,

BOARD OF TRUSTEES
October 2009

United Food and Commercial Workers & Employers Arizona Health & Welfare Trust

Estimado participante:

En Marzo de este año, se le envió una carta en donde se describían las nuevas regulaciones de Medicare. Estas reglas requieren que todos los planes de salud reporten los números de seguro social de TODAS las personas elegibles en el plan familiar a Medicare. Se aplicarán severas penalidades a los planes de salud que no cumplan con los requisitos de Medicare.

A esta fecha, nuestros expedientes demuestran que usted aun no ha proporcionado el número de seguro social de su(s) dependiente(s).

Adjunto a esta carta, se le ha enviado otra forma de inscripción. Por favor llene la forma y regrese la tan pronto le sea posible, se le a enviado un sobre de retorno para facilitarle el trámite. Si esta forma no se recibe a más tardar el 15 de Noviembre, **la elegibilidad de usted y sus dependientes podría no estar disponible a partir de enero del 2010.**

ATENCIÓN: Cada empleado o miembro de la familia que sea elegible para Medicare: ES NECESARIO QUE NOS ENVÍE EL NÚMERO DE IDENTIFICACIÓN DE MEDICARE, o si usted prefiere, simplemente envíenos una copia de su tarjeta de Medicare.

Entendemos que a muchos de ustedes les preocupe el hecho de dar los números de seguro social de su familia y nosotros entendemos su preocupación; es por eso que Southwest Service Administrators sigue todos los estándares gubernamentales cuando se trata de proteger su privacidad. Le informamos que el envío de datos a Medicare será hecho en un formato aprobado, asegurado y cifrado por el gobierno.

Para más información en cuanto a los requerimientos de Medicare, visite la página web www.cms.hhs.gov/MandatoryInsRep.

Gracias por su cooperación.

Atentamente,
MESA DIRECTIVA
Octubre de 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:	<input type="checkbox"/> M <input type="checkbox"/> F	2. BIRTH DATE / /	3. SOCIAL SECURITY # / /
4. ADDRESS <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> 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 NUMBER _____

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
	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES - SHOW NAME OF COVERED EMPLOYEE:	SOCIAL SECURITY #
MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	EFFECTIVE DATE OF COVERAGE:	/ /
IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD	NAME OF OTHER PLAN:	
IF YES, PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL, <input type="checkbox"/> DENTAL, <input type="checkbox"/> VISION	ADDRESS:	GROUP, I.D. OR HICN NUMBER:

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

MARRIAGE <input type="checkbox"/>	DIVORCE <input type="checkbox"/>	OTHER <input type="checkbox"/>	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
IF OTHER - PLEASE EXPLAIN:						
MARRIAGE <input type="checkbox"/>	DIVORCE <input type="checkbox"/>	OTHER <input type="checkbox"/>	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
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