

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 & COMMERCIAL WORKERS & EMPLOYERS
ARIZONA HEALTH & WELFARE FUND

RE: HEALTH INSURANCE OPEN ENROLLMENT FOR 2012

**YOUR ACTION IS REQUIRED ONLY IF YOU ARE MAKING CHANGES TO YOUR
CURRENT HEALTH INSURANCE ENROLLMENT!!!**

Open enrollment will begin on September 1st and end on October 15th. Any changes you make will be effective for the entire calendar year of 2012.

An Enrollment Form is enclosed. Complete it if you want to enroll in Health Insurance coverage for 2012 or if you want to make changes to your existing coverage level. This Enrollment period is the only time you will be able to make changes to your existing coverage or enroll in the Health Plan if you have not already done so.

DON'T DELAY!!! Enroll now for health insurance in 2012!!!!

Call your Trust Fund Office or visit your website at www.southwestservicetpa.com and click on UFCW & Employers AZ Health Fund to learn more about your benefit plan and services.

Customer Service Representatives (including Spanish) are available to take your questions from 8:30 am – 5:00 pm, Monday through Friday. Just call and press option 4 to speak with our Customer Care Department.

Sincerely,

Southwest Service Administrators, Inc.
602-249-3582 | Toll Free: 800-474-3485 | 602-249-3795

September 2011

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& EMPLOYERS AZ HEALTH & WELFARE TRUST**
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2012 OPEN 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 checked="" 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"/> Opt Out of Health Plan	
2.) Payroll Deduction Authorization					
<input type="checkbox"/> I authorize my employer <u> Name of Employer </u> to deduct from my weekly payroll for coverage as indicated below at the established amount set by 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 <u>after your (the Employee's) eligibility begins</u> ; if you want your spouse to be covered at that time we will notify your employer to begin the \$15 deduction <u>when your spouse is eligible</u> . 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		Medicare Eligible?	
		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<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?	Employer's Name and Address		Employers Phone	
	<input type="checkbox"/> Yes <input type="checkbox"/> No			() -	
					Coverage Type <input type="checkbox"/> Family <input type="checkbox"/> Single
What coverage does your spouse's employer provide?			Was the coverage accepted?		Medicare Eligible?
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> RX <input type="checkbox"/> None (check all that apply)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other _____		<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