UFCW LOCAL 655
WELFARE FUND
300 Weidman Road, Suite A
Ballwin, Missouri 63011
Phone | 314.835.2700 or 1.866.565.2700
Fax | 314.966.9848 | www.655hw.org

Enrollment Form

○ New Participant ○ Change Election ○ Add/Drop Spouse ○ Add/Drop Dependent Child ○ Update ○ Other_____

Acknowledgments

Please read all the statements below carefully. This section must be signed and dated before the Fund can process this form.

- **I certify that all the information I supply is true and correct.**
- **I understand that the purpose of this form is to either elect or decline benefits for myself and my family through Local 655 Welfare Fund.**
- **I understand that any intentional false statement made herein may void my coverage and will void benefits (if I choose to elect benefits).**
- **I understand that my enrollment election or declination may only be altered as the result of a life changing event.**
- **If I elect benefits below, I authorize my employer to deduct contributions from my pay.**
- **Should any changes take place affecting these statements, I will immediately inform the Welfare Fund.**

 Signature

Date

Enrollment Election or Declination

Your collective bargaining agreement may allow for your employer to deduct a weekly pre-tax employee contribution known as premium share and/or spousal surcharge. For these rates, please refer to your collective bargaining agreement located on your Local Union website.

For benefits the Plan provides please review your 2018 Summary Plan Description at www.655hw.org.

I elect benefits for the following: ○ Employee Only ○ Employee and Spouse ○ Employee and Child(ren) ○ Employee and Family

OR

I wish to DECLINE ALL benefits: ○ **I decline ALL Health and Welfare benefits.** I understand that I am declining medical, prescription drug, dental, vision care, life insurance, accidental death and dismemberment, short term disability and mental health and substance abuse benefits. Additionally, I understand that my family and I will not be eligible for any of the aforementioned benefits until the next annual open enrollment period, unless a life changing event occurs.

Smoker/Non-Smoker: ○ I am currently a smoker ○ I am NOT currently a smoker

Plan guidelines define smoking as the inhalation of burning tobacco, including cigarettes, cigars and pipes.

Participants Information

Participant's Full Legal Name	Participant's Preferred First Name

In order to process claims correctly we must be provided your gender at birth. Gender at Birth: ○ Female ○ Male

If you have legal documentation regarding gender identity, please submit with this form. Identify as: ○ Female ○ Male ○ Other_____	Local Union Affiliation ○ 655 ○ 881 ○ 534

Date of Birth	Social Security #	Employer's Name

Participant's Address (Street, City, State and Zip)

Participant's Phone #

Home Cell Work

Participant's E-mail Address

Personal Work

○ Single	○ Married (date)	○ Divorced (date)	○ Widowed (date)	○ Legally Separated (date)

continue

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Enrollment Form

Eligible Dependent Child(ren) to Enroll in Your Plan

Are you electing coverage foryour eligible children?

If you are electing coverage for your eligible children please submit a copy of your child's state-issued birth certificate along with a copy of your marriage license, regardless if you are enrolling your spouse. If the child(ren) were born prior to your current marriage, please submit a copy of your divorce decree and/or court order in full. If a divorce decree or court order does not exist, please request and complete a copy of the Fund's Notarized Form which will ask for custody arrangements and if the child is insured under any other Group Health Coverage.

If you are adding more than two children, please copy this form or visit our website at www.655hw.org to print more copies.

Dependent Child's Full Legal Name	Dependent Child's Preferred First Name

Gender at Birth: ○ Female ○ Male

In order to process claims correctly we must be provided a gender at birth.

Identify as: ○ Female ○ Male ○ Other_____

If there is legal documentation regarding gender identity, please submit with this form.

Date of Birth	Social Security #
Natural Mother's Name	Natural Mother's Date of Birth
Natural Father's Name	Natural Father's Date of Birth

Are the natural parents divorced?

○ Yes ○ No If yes, please list name and address of parent who has custody.

Have you sent a copy of your Divorce Decree or Custody Agreement to the Fund?

○ Yes ○ No If no, please submit a copy with this form.

Dependent Child's Full Legal Name	Dependent Child's Preferred First Name

Gender at Birth: ○ Female ○ Male

In order to process claims correctly we must be provided a gender at birth.

Identify as: ○ Female ○ Male ○ Other_____

If there is legal documentation regarding gender identity, please submit with this form.

Date of Birth	Social Security #
Natural Mother's Name	Natural Mother's Date of Birth
Natural Father's Name	Natural Father's Date of Birth

Are the natural parents divorced?

○ Yes ○ No If yes, please list name and address of parent who has custody.

Have you sent a copy of your Divorce Decree or Custody Agreement to the Fund?

○ Yes ○ No If no, please submit a copy with this form.

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Spouse to Enroll in Your Plan

If you are electing coverage for your legally married spouse you will need to submit a copy of your marriage license. If your spouse is employed you will need to complete and submit a Spousal Coverage Verification Form.

Please note the eligibility guidelines for spouses: If your spouse has other medical or prescription drug coverage available through their employer, and your spouse's employer subsidizes a portion of the cost, your spouse must elect coverage under that employer's plan. If your spouse does not elect coverage under their employer's Plan, your spouse will not be covered under the Welfare Fund Plan.

Spouse's Full Legal Name	Spouse's Preferred First Name

Gender at Birth: ○ Female ○ Male Gender Identity: ○ Female ○ Male ○ Other_____

If you have legal documentation regarding gender identity, please submit with this form.

Date of Birth	Social Security #	Is your spouse employed? ○ Yes ○ No or Self Employed

Spouse's Address (Street, City, State and Zip)	Date of Marriage

Spouse's Phone #

Home Cell Work

Spouse's E-mail Address

Personal Work

Other Insurance Information if Applicable

Do you or a family member have any other Group Health Benefits?

○ Yes If yes, please complete this section.

○ No If no, but patient did have coverage that ended, give date ended:_____ & complete next 3 lines AND submit copy of term letter.

Policy Holder's Name	Relationship To Patient	Policy Holder's Social Security #
Policy #	**Effective Date of Policy**	**Type of Coverage Under Policy** ○ Individual ○ Family
Is this an Employer policy? ○ Yes ○ No If Yes, please provide hire date_____.	Coverage's (please check all that apply) ○ Medical ○ Hospital ○ Dental ○ Vision ○ Mental Health ○ Prescription Drugs	

Name & Phone # of Insurance Company providing other coverage

Covered Dependents

Medicare Information if Applicable

Is the family member eligible for Medicare? If yes, please complete this section (9). Part A? ○ Yes ○ No Part B? ○ Yes ○ No

Subscriber's Name	Effective Date	Cancellation Date
	Part A? _____	Part A? _____
Subscriber's Social Securtiy #	Part B? _____	Part B? _____

Please note: If you have experienced a life changing event which allows you to modify your original enrollment election, please complete this form and submit any additional documentation to the Fund Office within 31 days of the event.