UFCW Northern California & Drug Employers Health and Welfare Trust
Fund P.O. Box 4100 • Concord, CA 94524-4100
www.ufcwtrust.com

OTHER INSURANCE INFORMATION

Beginning March 1, 2013, certain covered individuals (including spouses/domestic partners, and retirees) who have access to health group coverage offered by a current or former employer must enroll in that plan, **without regard to the cost of the plan.** If the employer has more than one plan option, the plan option selected must be at least as comprehensive as the UFCW Northern California & Drug Employers Health Plan (the Plan) in which they are currently enrolled.

- This change applies to any spouse or domestic partner with access to an active plan through a current employer or through a retiree plan through a former employer.
- This change applies to a working retiree with group coverage through a current or former employer. If a retiree is actively employed after the retiree's date of retirement from the Pension Fund, they must elect any coverage that is available to them through their current employer.
- A retiree, spouse or domestic partner who has other group coverage must enroll for coverage under the rules of the Fund, but are not required to enroll any dependents.
- The Plan will reduce benefit payments for a retiree, spouse or domestic partner who does not enroll in a plan available through his or her employer (current or former) or who does not enroll in the plan with benefits that are at least as comprehensive as the benefits under the UFCW Northern California & Drug Employers Health Plan.
- If a retiree, spouse or domestic partner is unable to enroll in an available group health plan until that plan's next open enrollment, the Plan will allow a one-time grace period until that other plan's next effective date of coverage. The Plan will require documentation from that plan stating enrollment at this time is not possible and identifying the date of the next open enrollment for that plan and the effective date of coverage. During this grace period, benefit payments will not be reduced. Signed certification on the employer's letterhead will be required to certify that a retiree, spouse or domestic partner does not have access to other group health insurance or that changes are not allowed outside of the open enrollment period.
- Members will be required to certify, under penalty of perjury, whether they or their spouse or domestic partner have access to other health coverage. In addition, members will be responsible for reimbursing the Plan for any amount paid by the Plan for them or on behalf of a spouse or domestic partner that should not have been paid.

Please complete and mail back to the Trust Fund the following questionnaire to the address above, including signature on last page.

If a working retiree, spouse or domestic partner are currently unable to enroll in the employer's health plan because of being outside of the employer's open enrollment period, documentation will be required from the employer on company letterhead identifying the date of the next open enrollment and that changes are not allowed outside of open enrollment.

What is the date of the next open enrollment period? _______________

What date will the plan become effective? _________________________

Section 1	PARTICIPANT/RETIREE INFORMATION			
Last Name	First Name	Initial	Gender ☐ M ☐ F	Social Security #
Mailing Address (Street or PO Box)	City	State	Zip Code	
Date of Birth	Current Marital Status ☐Divorced ☐Widowed ☐Domestic Partner ☐Single ☐Married	Date of Marriage/Divorce/Dom.Partner Certification		
Cell Phone Number	Home Telephone Number	E-Mail Address		

Section 2	Participant/Retiree Other Employment and Insurance			
2-A	If you are a ***retiree*** are you re-employed with another employer? ☐ Yes ☐ No If you are an ***active participant*** do you have other employment? ☐ Yes ☐ No	If "Yes", complete the remainder of Section 2. If "No", skip the rest of Section 2 and go to Section 3.		
	Name of your Employer:	Employer's Telephone:		
	Street Address of Employer:	City	State	Zip Code
Initial Here	**I acknowledge that if my employer does NOT offer medical coverage, a letter from my employer will be required verifying that coverage is not available. (Applies to a working retiree, spouse or domestic partner)**			
2-B	Is **Medical** coverage offered by your employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 2-B and go to Section 2-C.		
	i.) Are you enrolled in your employer's Medical Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 2-B. If "No", go to Section 2-C.		
	ii.) Name of Medical Insurance Carrier?			
	iii.) What type of plan is it? ☐ PPO ☐ HMO ☐ EPO ☐ POS			
	iv.) What date were you first covered under your current employer's medical plan?			
	v.) Who is covered under your current employer's medical plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family			
2-C	Is **Dental** coverage offered by your employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 2-C and go to Section 2-D.		
	i.) Are you enrolled in your employer's Dental Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 2-C. If "No", go to Section 2-D.		
	ii.) Name of Dental Insurance Carrier?			
	iii.) What type of plan is it? ☐ Indemnity ☐ DMO			
	iv.) What date were you first covered under your current employer's dental plan?			
	v.) Who is covered under your current employer's dental plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family			
2-D	Is **Prescription (Rx)** drug coverage offered by your current employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 2-D and go to Section 2-E.		
	i.) Are you enrolled in your employer's Rx Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 2-D. If "No", go to Section 2-E.		
	ii.) Name of Rx Plan insurance carrier?			
	iii.) What date were you first covered under your current employer's Rx plan?			
	iv.) Who is covered under your current employer's Rx plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family			
2-E	Is **Vision** coverage offered by your employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 2-E and go to Section 3.		
	i.) Are you enrolled in your employer's Vision Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 2-E. If "No", go to Section 3.		
	ii.) Name of Vision Plan insurance carrier?			
	iii.) What date were you first covered under your current employer's Vision plan?			
	iv.) Who is covered under your current employer's Vision plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family			
Section 3	SPOUSE/DOMESTIC PARTNER EMPLOYMENT AND INSURANCE			
Initial Here	**I acknowledge and understand that if my Spouse/Domestic Partner has access to benefits through their own current or former employment my Spouse/Domestic Partner must enroll in the plan that is at least as comprehensive as the UFCW Northern CA & Drug Employers Health & Welfare Trust Fund plan as soon as possible or my Spouse/Domestic Partner's benefits will be reduced.**			
Initial Here	**I acknowledge that if my Spouse/Domestic Partner's employer does NOT offer medical coverage, a letter from my Spouse/Domestic Partner's employer will be required verifying that coverage is not available.**			

3.1)	Are you: ☐ Married ☐ Domestic Partnership ☐ N/A	If, Married or Domestic Partnership continue to 3-A. If "N/A", skip Section 3 and go to Section 4.

3-A

Is your Spouse/Domestic Partner currently employed? ☐ Yes ☐ No			If "Yes", complete the remainder of Section 3. If "No", skip the rest of Section 3 and go to Section 4.
Name of your Spouse/Domestic Partner:			
Name of your Spouse/Domestic Partner's Employer:			Spouse/Domestic Partner's Employer Telephone:
Street Address of Employer:	City	State	Zip Code

3-B

Is **Medical** coverage offered by your Spouse/Domestic Partner's employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip Section 3-B and go to Section 3-C.
i.) Is your Spouse/Domestic Partner enrolled in their employer's Medical Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 3-B. If "No", go to question vi.
ii.) Name of Spouse/Domestic Partner's Medical Insurance Carrier?	
iii.) What type of plan is it? ☐ PPO ☐ HMO ☐ EPO ☐ POS	
iv.) What date was your Spouse/Domestic Partner first covered under their current employer's medical plan?	
v.) Who is covered under your Spouse/Domestic Partner's employer's medical plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family	
vi.) What is the date of the next open enrollment? _______________ What is the effective date of the plan? _______________ (Documentation will be required from Spouse/Domestic Partner's employer, on company letterhead, identifying the date of the next open enrollment and that changes are not allowed outside of open enrollment.)	

3-C

Is **Dental** coverage offered by your Spouse/Domestic Partner's employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 3-C and go to Section 3-D.
i.) Is your Spouse/Domestic Partner enrolled in their employer's Dental Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 3-C. If "No", go to Section 3-D.
ii.) Name of Dental Insurance Carrier?	
iii.) What type of plan is it? ☐ Indemnity ☐ DMO	
iv.) What date was your Spouse/Domestic Partner first covered under their current employer's Dental Plan?	
v.) Who is covered under your Spouse/Domestic Partner's employer's dental plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family	

3-D

Is **Prescription Drug (Rx)** coverage offered by your Spouse/Domestic Partner's employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 3-D and go to Section 3-E.
i.) Is your Spouse/Domestic Partner enrolled in their employer's Rx Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 3-D. If "No", go to Section 3-E.
ii.) Name of Rx Plan insurance carrier?	
iii.) What date was your Spouse/Domestic Partner first covered under their current employer's Rx plan?	
iv.) Who is covered under your Spouse/Domestic Partner's employer's Rx plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family	

3-E

Is **Vision** coverage offered by your Spouse/Domestic Partner's employer? ☐ Yes ☐ No	If "Yes", continue to question i. If "No", skip the rest of Section 3-E and go to Section 4.
i.) Is your Spouse/Domestic Partner enrolled in their employer's Vision Plan? ☐ Yes ☐ No	If "Yes", complete the rest of Section 3-E. If "No", go to Section 4.
ii.) Name of Vision Plan insurance carrier?	
iii.) What date was your Spouse/Domestic Partner first covered under their current employer's Vision plan?	
iv.) Who is covered under your Spouse/Domestic Partner's employer's Rx plan? ☐ Subscriber Only ☐ Subscriber & Spouse/Domestic Partner ☐ Subscriber & Children ☐ Subscriber & Family	

Section 4	OTHER INSURANCE COVERAGE FOR YOU OR YOUR DEPENDENT CHILDREN
4.1)	**Are any of your dependents who are currently covered under this Plan or dependents you are requesting to enroll in this Plan, also enrolled under any OTHER Employer Group Health Plan?** ☐ Yes ☐ No — If "Yes", complete Section 4. If "No", complete 4B.i and go to Section 4C.
4-A	Name of Medical Insurance Carrier:
	Is this Plan an/a: ☐ Active Employee ☐ Retiree — What type of plan is it? ☐ PPO ☐ HMO ☐ EPO ☐ POS
	What dates were your enrolled dependents or dependents you are requesting to enroll first covered under this plan?
	Subscriber's relationship to covered person: ☐ Self ☐ Spouse ☐ Parent ☐ Step-Parent
4-B	i.) Name of Dependent(s) covered under this plan: 1.) ____ 2.) ____ 3.) ____ 4.) ____
	With whom does the dependent reside: ☐ Mother ☐ Father ☐ Both ☐ Other (If "Other" please explain your living arrangement below.)
4-C	Are you receiving Social Security Disability Income (SSDI)? ☐ Yes ☐ No — If "Yes", what is your SSDI award date?
	Is your Spouse/Domestic Partner receiving Social Security Disability Income (SSDI)? ☐ Yes ☐ No — If "Yes", what is your Spouse/Domestic Partner's SSDI award date?
	Is any other enrolled dependent or dependent you are requesting to enroll receiving Social Security Disability Income (SSDI)? ☐ Yes ☐ No If "Yes", Dependent Name: ____ — If "Yes", what is your dependent's SSDI award date?
4-D-i	Are you eligible for Medicare? ☐ Yes ☐ No — Are you enrolled in Medicare? ☐ Yes ☐ No
	Eligibility Reason? ☐ Age (65 or older) ☐ End Stage Renal Disease ☐ ALS ☐ Disability or Railroad Retirement Board (RRB) Disability
	Effective date for Part A?
	Are you also enrolled in Part B? ☐ Yes ☐ No — Effective date for Part B?
	Are you enrolled in Part C? ☐ Yes ☐ No — Effective date for Part C?
4-D-ii	Is your Spouse/Domestic Partner eligible for Medicare? ☐ Yes ☐ No
	Is your Spouse/Domestic Partner enrolled in Medicare? ☐ Yes ☐ No
	Eligibility Reason? ☐ Age (65 or older) ☐ End Stage Renal Disease ☐ ALS ☐ Disability or Railroad Retirement Board (RRB) Disability
	Effective date for Part A?
	Is your Spouse/Domestic Partner also enrolled in Part B? ☐ Yes ☐ No — Effective date for Part B?
	Is your Spouse/Domestic Partner enrolled in Part C? ☐ Yes ☐ No — Effective date for Part C?
4-D iii	Are there any other enrolled dependents or dependents you are requesting to enroll under this plan eligible for Medicare? ☐ Yes ☐ No
	Are any of these dependents enrolled in Medicare? ☐ Yes ☐ No
	Name of Dependent(s): 1.) ____ 2.) ____ 3.) ____ 4.) ____
	Eligibility Reason? ☐ End Stage Renal Disease ☐ ALS ☐ Disability or Railroad Retirement Board (RRB) Disability
	Effective date for Part A?
	Are they also enrolled in Part B? ☐ Yes ☐ No — Effective date for Part B?
	Are they enrolled in Part C? ☐ Yes ☐ No — Effective date for Part C?

Section 5	PARTICIPANT & SPOUSE/DOMESTIC PARTNER CERTIFICATION (PLEASE READ AND SIGN BELOW)

FRAUD NOTICE: I understand that I may be subject to civil and/or criminal penalties for committing a fraudulent insurance act if I knowingly provide any materially false information to, or conceal any material facts from, the Trust Fund with the intent to defraud or mislead the Trust Fund.

DISCLOSURE OF CONFIDENTIAL INFORMATION: I understand that a physician, hospital, or other medically designated facility may be requested to furnish an agent, designee or representative of the Health Maintenance Organization (HMO), prepaid plan, or the Trust Fund any and all information or records pertaining to medical history, including services rendered, or treatment given to anyone enrolled now or added later for the purpose of utilization review, quality assurance, surveys, processing of claims, financial audit, or to perform administrative functions and that by participating in the Plan I am allowing such disclosures to be made. I also understand that the Trust Fund, its agents or employees, may need to disclose my, or my dependents', confidential information to others, including to the business partners, business associates and vendors of the Plan and/or the Trust Fund in order to provide you and your dependents, or inform you and your dependents of, additional benefits and opportunities provided by or made available through the Plan and/or the Trust Fund and/or the business partners, business associates and vendors of the Plan and/or the Trust Fund. I also understand that the Trust Fund, its agents or employees, may disclose my contact and demographic information to the union locals and contributing employers for their internal administrative purposes. Any such disclosures shall be in compliance with all applicable laws. The Trust Fund, its agents or employees, shall use all reasonable safeguards to ensure that any use or disclosure of my confidential information is solely for the purpose of administering benefits under the Plan and/or the other purposes set forth above.

ARBITRATION: I understand that any dispute or controversy which may arise between myself or any family member and a prepaid plan or HMO, or any of its providers, shall be settled by the prepaid plan's or HMO's final and binding arbitration rules, if any.

DECLARATION: I declare under penalty of perjury under the laws of the State of California that the information I provided as part of this enrollment process is true and correct to the best of my knowledge, and I consent to the provisions stated above during this enrollment process, which I have fully read and understand.

I understand that I am liable for any amounts paid by the Plan on behalf of myself, my spouse, domestic partner, or dependent child, that should not have been paid (for example, if the individual is not eligible for coverage under the plan, or if the individual has access to other group health coverage and does not enroll in that other coverage).

I acknowledge and understand that if I have access to benefits through my own current or former employment I must enroll in the plan that is at least as comprehensive as the UFCW Northern CA & Drug Employers Health & Welfare Trust Fund plan as soon as possible or my benefits will be reduced. (Applies to working retiree spouse or domestic partner)

Upon request from the Trust Fund Office, I agree to authorize the Trust Fund Office to obtain Social Security Administration (SSA) records to confirm information about my and my Spouse/Domestic Partner's employment.

SIGNATURE REQUIRED: *I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA 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.*

X	*Participant's Signature:* X	Date:
	Spouse/Domestic Partner's Signature: X	Date: