UFCWTRUST
Working For Your Benefit

Mail: P.O. Box 4100 Concord, CA 94524-4100
Telephone: (800) 552-2400
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www.ufcwtrust.com

UEBT ACTIVE
ULTRA BENEFIT LEVEL
ENROLLMENT FORM 3

INSTRUCTIONS **PLEASE READ AND COMPLETE ALL INFORMATION ON THIS FORM THAT APPLY TO YOUR HOUSEHOLD**

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

SECTION 1 PURPOSE FOR ENROLLMENT REQUEST

PLEASE CHECK ONE OF THE BOXES BELOW TO INDICATE IF THIS IS A NEW HIRE, TRANSFER OR A CHANGE ENROLLMENT REQUEST

☐ NEW HIRE
DATE OF HIRE: _____
☐ *RETURN FROM MILITARY

☐ CHANGE OF MARITAL STATUS
☐ CHANGE OF DEPENDENTS
☐ CHANGE OF CARRIER
☐ CHANGE OF NAME

☐ TRANSFER ENROLLMENT
☐ **TRANSFER FROM RECIPROCAL FUND
PRIOR JOB LOCATION/LOCAL: _____
DATE OF TRANSFER: _____

*** RETURN FROM MILITARY = ATTACH A COPY OF FORM DD-2214**

**** TRANSFER FROM RECIPROCAL FUND = IF RECIPROCAL FUND IS SOUTHERN CALIFORNIA WHOLESALE BUTCHERS, ATTACH A REQUEST FOR TRANSFER CREDITS FORM**

SECTION 2 COVERAGE SELECTION PLEASE NOTE: IF YOU MAKE A BENEFIT SELECTION THAT IS NOT CURRENTLY AVAILABLE TO YOU, YOUR REQUEST WILL BE DENIED

MEDICAL PLAN SELECTION:

☐ BLUE SHIELD PLAN (PPO) ☐ KAISER PLAN (HMO)

DENTAL PLAN SELECTION:

☐ CIGNA DENTAL ☐ DELTA DENTAL
☐ CYPRESS DENTAL ☐ LIBERTY DENTAL

SECTION 3 MEMBER INFORMATION

Last Name	First Name	Middle Initial	Gender	Member ID # / SSN	Union Local Number

Mailing Address (Street or P.O. Box)	City	State	Zip Code

Date of Birth	Current Marital Status	Date of Marriage / Divorce / Domestic Partner Certification
	☐ Never Married ☐Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	

Cell Phone Number	Home Telephone Number	Email Address

SECTION 4 DEPENDENT INFORMATION *(For additional dependents, write on the back of this form)*

TO ADD, CHANGE OR REMOVE COVERAGE FOR DEPENDENTS PLEASE REFER TO THE ATTACHED DOCUMENTATION SPECIFICATIONS FORM

Last Name	First Name	Relationship	Gender	Date of Birth	Dependent Social Security #

SECTION 5 BENEFICIARY OF DEATH BENEFIT

Complete a Death Beneficiary Change Form for all subsequent changes *(available at www.ufcwtrust.com)* **Total % Allocated must = 100%**

No benefits will be paid if the Death Benefit claim is received by the Trust Fund office more than one year after the Member or Dependent's death

Beneficiary's Last Name	First Name	Middle Initial	Relationship	Social Security # or Tax ID #	Percentage (%) Allocated

Street Address	City	State	Zip Code

Beneficiary's Last Name	First Name	Middle Initial	Relationship	Social Security # or Tax ID #	Percentage (%) Allocated

Street Address	City	State	Zip Code

SECTION 6 MEMBER / PARTICIPANT 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 DE-FRAUD OR MISLEAD THE TRUST FUND.

DISCLOSURE 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 INFORMATION, OR INFORMATION FOR 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 ME AND MY DEPENDENTS, OR INFORM ME AND MY 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.

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

This form cannot be accepted if it is not signed!

For questions or concerns please contact the Health and Welfare Services department at 1-800-552-2400

ACTIVE OTHER INSURANCE INFORMATION FORM

SECTION 1: INSTRUCTIONS

Why Does Other Insurance Information Matter?

Other Insurance can be defined as any other medical insurance, dental insurance, or prescription coverage that you or your dependents may have through an insurance policy other than the health benefits provided by the Plan.

For example, you may cover your dependent child under your health benefits provided by the Plan and at the same time, your Spouse/Domestic Partner may cover the same child under health insurance provided through your Spouse/Domestic Partner's own employer.

The Trust Fund needs to know if you, your Spouse/Domestic Partner and/or your dependent children are covered under any other health insurance so that we can coordinate payment of your health benefits. This will ensure your claims are paid correctly and on time.

SECTION 2: MY INFORMATION

Please provide your basic identification information

First Name _____ Last Name _____ Member ID # / SSN _____

Address _____

City _____ Zip _____ State _____

Home Phone _____ Cell Phone _____ Union Local _____

SECTION 3: COMPANY LETTER INQUIRY

Your Spouse/Domestic Partner is required to take other health insurance if insurance is offered by your Spouse/Domestic Partner's current or former employer. If your Spouse/Domestic Partner's employer does not offer insurance, you will be required to send the Trust Fund Office a letter on that employer's company letterhead stating that no insurance is offered. This letter is due back to the Trust Fund Office no later than 30 days from the date of this signed form.

☐ ✓ **Check this box if your Spouse/Domestic Partner (if applicable) is currently employed.**

If this box is ✓ checked, you will need to supply a letter from your Spouse/Domestic Partner's current employer on their company letterhead stating that no insurance is offered by the employer. Or if health insurance is offered by your Spouse/Domestic Partner's current or former employer, and your Spouse/Domestic Partner is enrolled in such insurance, please provide the other insurance information in **Section 4** *below*. If your Spouse/Domestic Partner's current or former employer offers health insurance, but your Spouse/Domestic Partner is not enrolled in such insurance, it is your responsibility to report this to the Trust Fund Office immediately.

SECTION 4: PROVIDE OTHER INSURANCE POLICY INFORMATION

If anyone in your family, including yourself, has other insurance, please fill out the insurance policy information and who is covered under that other insurance policy. Your family may have more than one other insurance policy, we ask that you provide the TFO with the details for each individual insurance policy.

Please ✓check whether the insurance is provided by an employer, the government, or ✓check "Any Other Coverage" if it is another type of health benefit coverage not listed.

If you have no other insurance coverage, please ✓check "None" and remember to initial and sign the last page of this questionnaire.

ACTIVE OTHER INSURANCE INFORMATION FORM

POLICY # 1 DETAILS CONTINUED FROM PAGE 1 (if applicable)

Check "None" if there are no other insurance policies for you or your enrolled dependents None ☐

Who is the main Subscriber for this other insurance policy?

_____

Is this for an Active or Retiree Plan?

Active Plan ☐ Retiree Plan ☐

Who is covered under this policy (if any), list any family members that are covered under this insurance policy?

What type of policy is this? Employer Insurance ☐ Government Insurance ☐ Any Other Coverage ☐

If Medicare, what part(s)? Part A ☐ Part B ☐ Part C ☐ Part D ☐

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Medical Insurance? _____

What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)? _____

If this Dental Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Prescription (Rx) Insurance? _____

POLICY # 2 DETAILS (if applicable)

Check "None" if there are no other insurance policies for you or your enrolled dependents None ☐

Who is the main Subscriber for this other insurance policy?

_____

Is this for an Active or Retiree Plan?

Active Plan ☐ Retiree Plan ☐

Who is covered under this policy (if any), list any family members that are covered under this insurance policy?

What type of policy is this? Employer Insurance ☐ Government Insurance ☐ Any Other Coverage ☐

If Medicare, what part(s)? Part A ☐ Part B ☐ Part C ☐ Part D ☐

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Medical Insurance? _____

ACTIVE OTHER INSURANCE INFORMATION FORM

What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)?

If this Dental Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Prescription (Rx) Insurance? _____

POLICY # 3 DETAILS (if applicable)

Check "None" if there are no other insurance policies for you or your enrolled dependents None ☐

Who is the main Subscriber for this other insurance policy?	Is this for an Active or Retiree Plan?
_____	Active Plan ☐ Retiree Plan ☐

Who Is Covered under this policy (if any), list any family members that are covered under this insurance policy?

What type of policy is this? Employer Insurance ☐ Government Insurance ☐ Any Other Coverage ☐

If Medicare, what part(s)? Part A ☐ Part B ☐ Part C ☐ Part D ☐

What is the Medical Insurance Carrier Name (i.e. Blue Shield / Kaiser)? _____

If this Medical Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Medical Insurance? _____

What is the Dental Insurance Carrier Name (i.e. Delta / Premier Access)? _____

If this Dental Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Dental Insurance? _____

What is the Prescription (Rx) Insurance Carrier Name (i.e. Envision / Optum)? _____

If this Prescription (Rx) Insurance is an HMO, ✓check this box ☐

What is the effective start date for the Prescription (Rx) Insurance? _____

Any Other Policy Details (if applicable), Please use the backside of this form.

ACTIVE OTHER INSURANCE INFORMATION FORM

SECTION 5: SIGNATURE AND CERTIFICATION *(Please read and sign below)*

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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.

_____ ***Initial Here***	I ACKNOWLEDGE AND UNDERSTAND THAT I AM LIABLE FOR ALL CLAIMS FOR DEPENDENTS DEEMED INELIGIBLE.	
_____ ***Initial Here***	I ACKNOWLEDGE AND UNDERSTAND THAT IF MY ENROLLED 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 UEBT ACTIVE PLAN OR MY SPOUSE/DOMESTIC PARTNER BENEFITS WILL BE REDUCED. IF MY SPOUSE/DOMESTIC PARTNER'S EMPLOYER DOES NOT OFFER MEDICAL AND/OR DENTAL COVERAGE, A LETTER FROM MY SPOUSE/DOMESTIC PARTNER'S EMPLOYER WILL BE REQUIRED VERIFYING THAT COVERAGE IS NOT AVAILABLE.	
X ***Sign Here***	Member's Signature:	Date:
X ***Sign Here***	Spouse/Domestic Partner's Signature (if applicable):	Date:

This form cannot be accepted if it is not signed!

For questions or concerns please contact the Health and Welfare Services department at 1-800-552-2400

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UFCW & EMPLOYERS BENEFIT TRUST
AUTHORIZATION FOR PAYROLL DEDUCTION FOR EMPLOYEE PREMIUM CONTRIBUTION

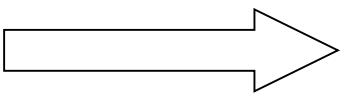
NAME _____LAST 4 DIGITS OF **SOCIAL SECURITY NO.**_____
(PLEASE PRINT)

I hereby request the Trust Fund Office (TFO) establish coverage for the dependents I am enrolling under the UFCW & Employers Benefit Trust Fund, as listed below.

I authorize my employer to withhold the required weekly premium amount from my paycheck and to remit the payment directly to the UFCW & Employers Benefit Trust Fund. If I qualify for participation in the Wellness Program, sometimes referred to as Health Care Partnership (or "HCP"), my Wellness Program (HCP) premium amount for coverage of my enrolled dependents will be the weekly amount shown on the back of this page under the heading "Wellness Program Premiums" based on the number of dependents enrolled on my plan. I acknowledge that if I do not complete all of the Wellness Steps required to be eligible to participate in the Wellness Program (HCP), I will be deemed to have instead elected not to participate in the Wellness Program. If I am not eligible to participate in the Wellness Program, my Non-Wellness Program premium amount for coverage of my enrolled dependents will be the weekly amount shown on the back of this page under the heading "Non-Wellness Program Premiums" based on the number of dependents enrolled on my plan. If I graduate into a higher benefit level and my dependent premium rates are reduced as a result of my graduation, I expressly authorize my Employer to withhold the required premium amount for coverage of my enrolled dependents related to my new benefit level. I understand that if my Employer cannot deduct the required premium amount from my paycheck, the Trust Fund Office will bill me for the required premium amount, and that it is my responsibility to make timely payments to the UFCW & Employers Benefit Trust Fund by the applicable due date, or coverage of my dependents will be suspended.

I understand that if my employer maintains a "cafeteria plan" under Internal Revenue Code Section 125, the required premium amounts will be withheld on a pre-tax basis, unless I affirmatively elect to decline coverage. I expressly authorize these required premium amounts to be withheld on a pre-tax basis and I understand that my authorization will stay in effect for future years if I do not make any election changes and if the premium amounts for coverage remain the same. I also understand that I cannot change my coverage elections during the plan year unless I experience a change in status event which would permit such a change under the Plan (regardless of whether or not the required premium amounts are withheld on a pre-tax basis). In addition, if these required premium amounts are withheld on a pre-tax basis, I understand that I also cannot change my elections unless the change is also permitted under the applicable cafeteria plan rules.

I understand that, in order to establish coverage for my dependent(s), I must continue to satisfy the Plan's eligibility rules, including the hours' requirements for dependent coverage, and I must pay the required premium amount for the month in advance of the month of coverage.



Please check the appropriate box(es) below based on your current Plan level and the elections made during the Graduation process:

Level of Coverage	**Weekly Rates**		
Ultra Plan			
Wellness Program (HCP) Premiums	☐ Employee	$0 *(I only want coverage for myself)*	
	☐ Spouse/Domestic Partner	$20 ☐ 1 Child	$15
	☐ 2 Children	$30 ☐ 3 Children or more	$45
Non-Wellness Program Premiums	☐ Employee	$0 *(I only want coverage for myself)*	
	☐ Spouse/Domestic Partner	$35 ☐ 1 Child	$20
	☐ 2 Children	$40 ☐ 3 Children or more	$60

TOTAL WEEKLY PREMIUM AMOUNT AUTHORIZED (PLEASE USE CHART ABOVE TO CALCULATE): $_____

SIGNATURE: _____ DATE: _____

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DOCUMENTATION SPECIFICATIONS
UEBT ACTIVE
FORM 7

INSTRUCTIONS — **TO ADD, CHANGE, OR REMOVE COVERAGE FOR DEPENDENTS, A COPY OF THE FOLLOWING DOCUMENTATION IS REQUIRED (PLEASE NOTE ORIGINAL DOCUMENTS WILL NOT BE RETURNED.)**

TO ADD A DEPENDENT

DOCUMENTATION REQUIREMENT		TIMELINE REQUIREMENT
SPOUSE:	• COUNTY ISSUED MARRIAGE CERTIFICATE **AND ONE OF THE FOLLOWING:** • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN WITH YOUR SPOUSE LISTED OR ACKNOWLEDGMENT OF YOUR TAX EXTENSION (FORM 4868) (PLEASE COVER UP FINANCIAL INFORMATION) • RECENT (WITHIN **60** DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR SPOUSE'S NAME AT YOUR ADDRESS	**SPOUSE OR DOMESTIC PARTNER** • **ULTRA/PREMIER MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT (**60** DAYS FOR HMO ENROLLMENT)
DOMESTIC PARTNER:	• CERTIFICATE OF REGISTRATION OF DOMESTIC PARTNERSHIP (CRDP) ISSUED BY THE CALIFORNIA SECRETARY OF STATE **AND:** • RECENT (WITHIN **60** DAYS) RECURRING HOUSEHOLD BILL OR ACCOUNT STATEMENT LISTING YOUR DOMESTIC PARTNER'S NAME AT YOUR ADDRESS	
NEWBORN CHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE ***NOTE:*** *If you do not have the County Issued Birth Certificate by stated deadlines, submit the Hospital Issued Birth Certificate and proof that you applied for your child's County Birth Certificate within* ***60*** *days of the date of birth (for both PPO or HMO) for six months of temporary coverage beginning at date of birth. The County Issued Birth Certificate must be received by the Trust Fund Office no later than 6 months after the date of birth.*	**NEWBORN CHILD** • **ULTRA/PREMIER MEMBER** = WITHIN **90** DAYS OF DATE OF BIRTH (**60** DAYS FOR HMO ENROLLMENT)
NATURAL CHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE	**CHILD DEPENDENT** • **ULTRA/PREMIER MEMBER** = WITHIN **90** DAYS OF QUALIFYING EVENT (**60** DAYS FOR HMO ENROLLMENT) OR DATE OF PLACEMENT (FOSTER/ADOPTION)
STEPCHILD:	• COUNTY-ISSUED BIRTH CERTIFICATE **PLUS:** • COUNTY-ISSUED MARRIAGE CERTIFICATE WITH NATURAL PARENT	
ADOPTED CHILD:	• COURT ADOPTION PAPERS	
FOSTER CHILD:	• FOSTER HOME LICENSE **PLUS:** • LEGAL GUARDIANSHIP PAPERS FOR THE CHILD	
OVERAGE DISABLED DEPENDENT: *(Must be renewed annually)*	• DISABLED OVERAGE DEPENDENT CHILD FORM ***GO TO WWW.UFCWTRUST.COM TO DOWNLOAD THE FORM OR CALL 1-800-552-2400*** • PROOF OF CURRENT SOCIAL SECURITY DISABILITY AWARD LETTER • PAGE 1 OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN SHOWING CHILD LISTED **PLUS:** • ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS CHILD BELONGS: NATURAL CHILD, STEPCHILD, ADOPTED CHILD, OR FOSTER CHILD	

TO ADD A DEPENDENT BECAUSE OF CURRENT LOSS OF COVERAGE

ANY DEPENDENT TYPE:	• ALL DOCUMENTS REQUIRED FROM ONE (1) OF THE CATEGORIES ABOVE FOR WHICH THIS DEPENDENT BELONGS: SPOUSE, DOMESTIC PARTNER, NEWBORN, NATURAL CHILD, STEPCHILD, ADOPTED CHILD, FOSTER CHILD OR OVERAGE DISABLED DEPENDENT CHILD **PLUS:** • A HIPAA CERT OR A COBRA NOTICE TO PROVE LOSS OF COVERAGE	**ANY DEPENDENT TYPE** • **LOSS OF COVERAGE** = WITHIN 30 DAYS FROM LOSS OF COVERAGE

WHEN ADDING A DEPENDENT PLEASE ATTACH A COMPLETED OTHER INSURANCE INFORMATION SURVEY AND AN AUTHORIZATION TO DEDUCT FORM

TO REMOVE A DEPENDENT

DIVORCE OF SPOUSE:	• FINAL DIVORCE DECREE ENTERED WITH THE COURT
DISSOLUTION OF DOMESTIC PARTNERSHIP:	• FINAL JUDGMENT OF DISSOLUTION OR TERMINATION OF DOMESTIC PARTNERSHIP PAPERWORK
DEPENDENT DEATH:	• CERTIFIED DEATH CERTIFICATE

PLEASE MAIL YOUR DOCUMENTS TO:

UFCW & EMPLOYERS TRUST, LLC
P.O. BOX 4100
Concord, CA 94524-4100

20240212