UFCW NATIONAL HEALTH and WELFARE FUND

66 Grand Avenue • Englewood, New Jersey 07631-3545 • (201) 569-8801 • Fax (201) 569-1085 • www.ufcwnationalfund.org

EMPLOYEE INFORMATION (Please print neatly in black ink or type)

Social Security Number	Name: First	Middle	Last

Residence Address: (Not Post Office Box) City State Zip Code

Telephone Number	Local Union	Date of Birth			Gender	Marital Status
( )		MM	DD	YYYY	☐ Male ☐ Female ☐ Other _____	☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of event: ____/____/____

Email Address: The National Fund does not share or sell your email address to any party without your written request.

Employer Name: Employer City/State:

SPOUSE INFORMATION *If spouse is to be enrolled, initial here _____

Social Security Number	Name: First	Middle	Last	Gender	Date of Birth
				☐ Male ☐ Female	____/____/____

Is your spouse: ☐ Employed ☐ Retired ☐ Not Employed Name of Spouse's Employer:

Is health coverage of any type offered? ☐ Yes ☐ No If yes, ☐ Individual ☐ Family

Name of Plan: _____ ID or Policy #: _____

Is there a cost to you for this coverage? ☐ Yes ☐ No

Did you decline the coverage? ☐ Yes ☐ No If no, when did coverage start? _____

DEPENDENT INFORMATION ** If dependent(s) is/are to be enrolled, initial here _____

First Name and Middle Initial **(Last Name if Different from Employee)**	Date of Birth (MM/DD/YY)	Social Security Number	Dependent Relationship
1.			☐ Son ☐ Daughter
2.			☐ Son ☐ Daughter
3.			☐ Son ☐ Daughter
4.			☐ Son ☐ Daughter

*** Please submit a copy of the marriage certificate.** **** Please submit a copy of the birth certificate(s).**

I acknowledge that this application for coverage is contingent on the complete, accurate disclosure of the information requested on this form. I certify that the statements on this application are true and complete. I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination of coverage. I agree to be bound by the terms and conditions of the UFCW National Health and Welfare Fund Plan of Benefits and understand that any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Date: _____ Employee's Signature: _____

EMPLOYER USE ONLY

Coverage Tier (if applicable): _____ Date of Hire: _____ Date Eligible for Benefits: _____

Employer's Signature: _____ Date: _____

FUND OFFICE USE ONLY

Received: _____ By: _____ SPD/ID Ordered: _____ Mailed: _____

Notes: _____

Dear Participant:

The staff of the National Fund Office considers it a privilege to administer a health and welfare program for you and your eligible dependents.

Our procedures require that this enrollment form be completed so that we have an accurate record of everyone who is covered for benefits along with any supporting documents required.

Please fill out the form, making sure to type or print legibly all of the information you provide. The employee should sign and date the form at the bottom where indicated.

As soon as we receive this information, we will be able to take all of the necessary actions to process claims and provide you with the benefits to which you are entitled. It is, thus, important to make this form as complete as possible and give it to your Human Resource Department, employer representative or directly to the National Fund Office.

If you need more room to provide information to the National Fund Office, please use the bottom of this letter or attach a separate sheet of paper.

If you have any questions, please call the National Fund Office at 1-888-773-8329.

Sincerely,

Glenn L. Di Biasi
Fund Administrator

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WWW.UFCWNATIONALFUND.ORG

PRINT ADDITIONAL INFORMATION HERE