UFCW NATIONAL FUND
small enough to care...BIG enough to make a difference!®

66 Grand Avenue • Englewood, New Jersey 07631-3545
• (201) 569-8801 • Fax (201) 569-1085 or JFax@UFCWS.com
• www.UFCWS.com • Help@UFCWS.com

DATE:

Dear Member/Insured:

Because of changing family circumstances that may affect medical coverage, this important information is required each year to update our records. Your health care coverage includes a Coordination of Benefit provision that determines which coverage pays first when you are covered by more than one plan. In order for us to process your claim(s), we need the following information to determine the primary carrier for the patient on this claim. The claim cannot be processed without the requested information.

Member Name:	
UFN # or UFD#	
Member Email	
Member Phone (optional)	

Enter your answers in the space provided. The fields will expand to accommodate your answers.

1.	Name of Spouse			2.	Spouse SSN		-		-							
3.	Spouse Date of Birth		4.	Is spouse employed?	No (if No skip to question # 12)		Yes									
5.	Does your spouse's employer offer medical coverage of any type?						No		Yes							
6.	Please provide name and complete address of your spouse's employer.															
7.	If coverage is offered, is it single or family coverage?				Single Coverage		Family Coverage									
8.	Is there a cost to your spouse for this coverage?	No		Yes		Amount $ Month										
9.	Provide full name and address of spouse's insurance company (including ID # and Group Number).															
10.	Did your spouse decline medical coverage offered by his/her employer?				No (go to # 12)		Yes									
10a.	Did your spouse receive any economic inducement, incentive or benefit for declining coverage offered by your spouse's employer.						No		Yes							
10b.	If yes, please describe the inducement. (direct payment, contribution to a Flexible Spending Account, other benefits (childcare, etc.)															
11.	What was the effective date of your spouse's coverage:	Month		Day		Year										

12.	Please list First and Last name(s) of ALL dependents (including spouse) that are included in your coverage.							
13.	If both you and Spouse are not the children's natural parents, please complete the following: (If divorced, please provide copy of divorce decree.)							
	Child's Name (Last & First)	Custodial Parent	Court ordered Payment of Healthcare Expense				Parent's Name	Insurance Carrier
			No		Yes			
			No		Yes			
			No		Yes			
			No		Yes			
			No		Yes			
			No		Yes			

I HEREBY CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IS TRUE AND CORRECT.

Insurance disclaimer

Member signature:		Date:	

Very Truly Yours,

Claims Processing Department