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

New Member Information Form[i]

After filling out this electronic form, kindly send it to our offices via email, efax, or postal mail. Please ensure that you include all required supplemental information.

Employee Information[ii] (Please fill in the fillable PDF form or use black ink)																					
Name: First:		Middle:		Last:		SSN:[iii]															
Street Address[iv]:		City:		State:		Zip:															
Phone: [v]		Mobile (Optional)		Local Union:																	
Date of Birth:	MM		DD		YYYY		Gender:	Male		Female		Other									
Email Address:							The National Fund does not share or sell your email address to any party.														
Marital Status:	Single		Married [vi]		Widowed		Divorced/Leg. Separated [vii] [viii]		Date of Event	MM		DD		YYYY							
Employer Name:		Employer City/State:																			

Spouse Information[ix] [x] (Complete this section if you are enrolling your spouse.)																					
Spouse: First:		Middle:		Last:		SSN:															
Date of Birth:	MM		DD		YYYY		Gender:	Male		Female		Other									
Is your spouse:	Employed		Retired		Not Employed																
If employed Is health coverage of any type offered?		Yes		No		If Yes:	Individual		Family												
Employer Name:		Employer Address:																			
Employer Phone:		Name of Plan:				ID or Policy #															
Is there a cost for this coverage?	Yes		No		Did you decline coverage?		Yes		No												
If coverage is active what is the effective date		MM		DD		YYYY															

Child Information [xi] [xii] [xiii] [xiv] (Complete this section if you are enrolling your children.)						
	First Name and Middle Initial **(add Last Name if Different from Employee)**	Date of Birth			Social Security Number	Dependent Relationship	
		MM	DD	YYYY		Daughter	Son
1							
2							
3							
4							
5							

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 this application for an insurance policy or in connection with a claim for benefits is subject to losing my continued eligibility health coverage through the Fund and possible to criminal and civil penalties.

By providing the information contained in this form, I further understand and authorize the Fund, its representatives, and/or its third-party service providers to contact me by telephone, cell phone, e-mail, or mail, for purposes of Fund administration and healthcare related activities such as enrollment or medical management. I understand I may revoke my consent to receive such calls or messages sent to my cell phone at any time.

Employee Signature: _____ Date: _____

Employer Use Only					
Coverage Tier (if applicable):		Date of Hire:		Date Eligible for Benefits:	
Employer's Signature		Date:			

Fund Use Only							
Received Date:		By:		SPD/ID Ordered:		Mailed:	
Notes:							

07/24

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

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. (Your typed signature on the fillable form is acceptable.)

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. Your Human Resource department can also complete this fillable PDF form electronically.

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.

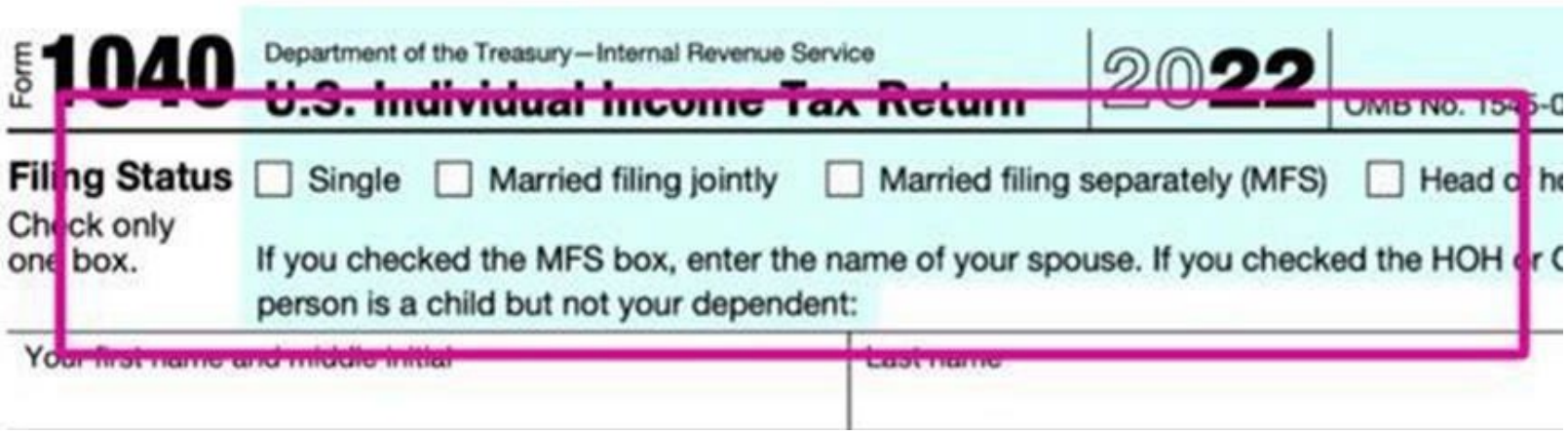
If you have any questions, please call the National Fund Office at 1-888-773-8329.

Sincerely,

Glenn L. Di Biasi, Fund Administrator

Print or Type Additional Information Here

[i] Please note that several sections of this form request **additional information**. These end notes provide guidance about those items. Please call us if you have any questions.
[ii] If you are disabled, please provide proof of disability. (Social Security Administration Supplemental Security Income Notice of Award)
[iii] Enter all Social Security Numbers as numeric digits. The field will format them. Example: 012345678 will become 012-34-5678.
[iv] Please provide your street address, not a Post Office Box.
[v] Phone number should be entered as a string of numbers. Example: 1234567890 will become (123) 456-7890.
[vi] If you are in a domestic partnership, please request and complete the Affidavit available from the Funds and include it with your application.
[vii] Your family is not covered if you are either divorced or legally separated. **Please provide** a copy of the divorce decree or legal separation agreement with your application.
[viii] Please provide page 1 of your most recent 1040 showing your filing status selection. We **do not need or wish to see** any of the financial information included in your taxes.



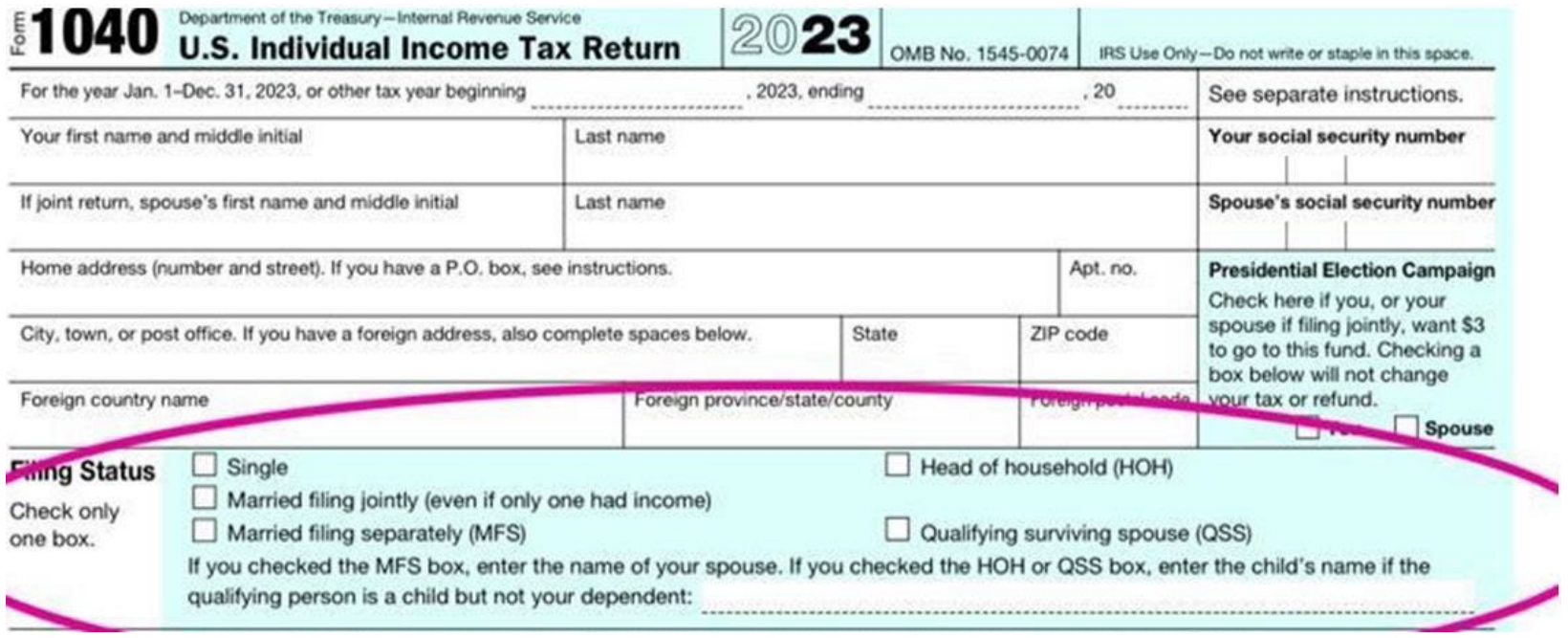
Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** 2022 OMB No. 1545-0

Filing Status ☐ Single ☐ Married filing jointly ☐ Married filing separately (MFS) ☐ Head of he

Check only one box.

If you checked the MFS box, enter the name of your spouse. If you checked the HOH or Q person is a child but not your dependent:

Your first name and middle initial | Last name



Form **1040** Department of the Treasury—Internal Revenue Service **U.S. Individual Income Tax Return** 2023 OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2023, or other tax year beginning _____, 2023, ending _____, 20____ See separate instructions.

Your first name and middle initial	Last name	**Your social security number**
If joint return, spouse's first name and middle initial	Last name	**Spouse's social security number**
Home address (number and street). If you have a P.O. box, see instructions.	Apt. no.	**Presidential Election Campaign** Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund.
City, town, or post office. If you have a foreign address, also complete spaces below.	State / ZIP code	
Foreign country name	Foreign province/state/county / Foreign postal code	☐ You ☐ Spouse

Filing Status Check only one box.

☐ Single ☐ Head of household (HOH)
☐ Married filing jointly (even if only one had income)
☐ Married filing separately (MFS) ☐ Qualifying surviving spouse (QSS)

If you checked the MFS box, enter the name of your spouse. If you checked the HOH or QSS box, enter the child's name if the qualifying person is a child but not your dependent: _____

[ix] Please submit a copy of your marriage certificate.

[x] You will need to complete our Coordination of Benefits form if you are requesting coverage for your spouse or children.

[xi] Please submit a copy of each child's birth certificate.

[xii] If child has been adopted, please furnish a copy of the adoption papers.

[xiii] For legal guardianship, etc., please furnish a copy of the judgment.

[xiv] If you are not the child's natural parent, please provide the name and date of birth of the child's natural mother/father (the parent who is not on the plan).
Does the natural [mother/father] carry insurance for the child[ren]? If yes, please submit a copy of the insurance card. If not, a note stating that there is no insurance provided will suffice.