

66 Grand Avenue, Englewood, NJ 07631

PHONE

201.569.8801

FAX

201.569.1085

1212 West Robinhood Drive, #3E, Stockton, CA 95207

209-952-6533

209-952-7325

NEW MEMBER INFORMATION FORMⁱ

After filling out this electronic form, kindly send it to our offices via email, e-fax, or postal mail.

Please ensure that you include all required supplemental information.

EMPLOYEE INFORMATIONⁱⁱ (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*: _____ The National Fund does not share or sell your email address to any party.

Marital Status*: Single Married^{vi} Widowed Divorced/Legally 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: _____ SSNⁱⁱⁱ _____

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 Gender		
		MM/DD/YYYY		Male	Female	Other
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____



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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 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 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.

Best regards,

Glenn L Di Biasi

Glenn L. Di Biasi
Fund Administrator

*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.

[†] If you are disabled, please provide proof of disability. (Social Security Administration Supplemental Security Income Notice of Award)

[‡] Enter all Social Security Numbers as numeric digits. The field will format them. Example: 012345678 will become 012-34-5678.

[§] Please provide your street address, not a Post Office Box.

[¶] Phone number should be entered as a string of numbers. Example: 1234567890 will become (123) 456-7890.

^{¶¶} If you are in a domestic partnership, please request and complete the Affidavit available from the Funds and include it with your application.

^{¶¶¶} 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.

^{¶¶¶¶} 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.

Print or Type Additional Information Here



Scan or visit **UFCWS.COM**



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Form **1040** Department of the Treasury—Internal Revenue Service **2023** U.S. Individual Income Tax Return 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

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. _____

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 _____

Filing Status Single Head of household (HOH)
 Married filing jointly (even if only one had income)
 Married filing separately (MFS) Qualifying surviving spouse (QSS)
 Check only one box. If you checked the HOH or QSS 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: _____

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.
 You Spouse

Form **1040** Department of the Treasury—Internal Revenue Service **2024** U.S. Individual Income Tax Return OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2024, or other tax year beginning _____, 2024, ending _____, 20

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. _____

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 _____

Filing Status Single Head of household (HOH)
 Married filing jointly (even if only one had income)
 Married filing separately (MFS) Qualifying surviving spouse (QSS)
 Check only one box. 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: _____
 If treating a nonresident alien or dual-status alien spouse as a U.S. resident for the entire tax year, check the box and enter their name (see instructions and attach statement if required): _____

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.
 You Spouse

- ^{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.

