UFCW NATIONAL FUND
small enough to care...BIG enough to make a difference!®
UFCWS.com
66 Grand Avenue, Englewood, NJ 07631 PHONE 201.569.8801 FAX 201.569.1085
1212 West Robinhood Drive, #3E, Stockton, CA 95207 PHONE 209-952-6533 FAX 209-952-7325

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*: ____

Marital Status*: Single ☐ Married[vi] ☐ Widowed ☐ Divorced/Legally Separated[vii viii]" ☐ Date of Event: MM/DD/YYYY ____

The National Fund does not share or sell your email address to any party.

Employer Name*: ____ Employer City/State*: ____

SPOUSE INFORMATION[ix x] (Complete this section if you are enrolling your spouse.)

Spouse: First: ____ Middle: ____ Last: ____ SSN[iii] ____

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 MM/DD/YYYY	Social Security Number	Dependent Gender		
				Male	Female	Other
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:

*Required Field 05/25