UFCW
a VOICE for working America

WELFARE FUNDS of LOCAL 464A

HEALTHCARE COVERAGE ENROLLMENT FORM

245 PATERSON AVENUE
LITTLE FALLS, NJ 07424
PHONE - (973) 256-5803
FAX - (973) 256-0399

YOU MUST COMPLETE ALL THE INFORMATION REQUESTED ON THIS FORM
ANY FORM THAT IS INCOMPLETE OR UNSIGNED WILL DELAY COVERAGE

MEMBER'S FULL NAME			SOCIAL SECURITY NUMBER	MALE ☐ FEMALE ☐	BIRTH DATE
MEMBER'S MAILING ADDRESS			HOME TELEPHONE NUMBER	CELL PHONE NUMBER	
CITY	STATE	ZIP CODE	EMPLOYER & LOCATION		

Single: ☐ Married: ☐ ________ DATE (include a copy of marriage certificate) Civil Union: ☐ ________ DATE Separated: ☐ ________ DATE Divorced: ☐ ________ DATE Widowed: ☐ ________ DATE

SPOUSE'S FULL NAME		MALE ☐ FEMALE ☐	SPOUSE'S EMPLOYER
SPOUSE'S MAILING ADDRESS			EMPLOYER ADDRESS
CITY	STATE	ZIP CODE	EMPLOYER CITY, STATE, ZIP CODE
SPOUSE'S SOCIAL SECURITY NUMBER	SPOUSE'S BIRTH DATE		EMPLOYER PHONE NUMBER

Do you have another Full or Part-Time Job? YES ☐ NO ☐ Full-Time? ☐ Part-Time? ☐ EMPLOYER NAME/ADDRESS/TELEPHONE NUMBER

LIST ANY OTHER HEALTHCARE COVERAGE PROGRAM THAT YOU ARE ENROLLED IN:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER MEMBER/SPOUSE/PARENT	TELEPHONE NUMBER	EFFECTIVE DATE	CHECK COVERED PERSONS SELF	SPOUSE	CHILDREN
MEDICAL					☐	☐	☐
PRESCRIPTION					☐	☐	☐
DENTAL					☐	☐	☐
VISION					☐	☐	☐

LIST ANY OTHER HEALTHCARE COVERAGE PROGRAM THAT YOUR SPOUSE IS ENROLLED IN:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER MEMBER/SPOUSE/PARENT	TELEPHONE NUMBER	EFFECTIVE DATE	CHECK COVERED PERSONS SELF	SPOUSE	CHILDREN
MEDICAL					☐	☐	☐
PRESCRIPTION					☐	☐	☐
DENTAL					☐	☐	☐
VISION					☐	☐	☐

I HEREBY DESIGNATE THE FOLLOWING INDIVIDUAL AS A DEATH BENEFIT BENEFICIARY:

BENEFICIARY'S FULL NAME			BENEFICIARY'S SOCIAL SECURITY NUMBER
BENEFICIARY'S MAILING ADDRESS			BENEFICIARY'S HOME TELEPHONE NUMBER
CITY	STATE	ZIP CODE	BENEFICIARY IS MY: Spouse ☐ Parent ☐ Child ☐ Brother: ☐ Sister: ☐ Other: ☐ ________

I Certify that under penalty of perjury, all information stated on this form is true and correct.

Member's signature **Date**

ALLIED PRINTING TRADES UNION LABEL COUNCIL PATERSON 12

FORM NO. 8-5 Rev. 1/14

LIST YOUR ELIGIBLE CHILDREN (FT MEMBERS ONLY)-INCLUDE A COPY OF EACH CHILD'S BIRTH CERTIFICATE

CHILD'S FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SON ☐ DAUGHTER ☐	STEP-CHILD ☐ ADOPTED ☐
CHILD'S ADDRESS IF DIFFERENT	CITY		STATE	ZIP CODE
STATE CHILD'S FULL-TIME/PART-TIME EMPLOYER:	EMPLOYER ADDRESS:			EMPLOYER TELEPHONE NUMBER:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER	TELEPHONE NUMBER	EFFECTIVE DATE
MEDICAL				
PRESCRIPTION				
DENTAL				
VISION				

CHILD'S FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SON ☐ DAUGHTER ☐	STEP-CHILD ☐ ADOPTED ☐
CHILD'S ADDRESS IF DIFFERENT	CITY		STATE	ZIP CODE
STATE CHILD'S FULL-TIME/PART-TIME EMPLOYER:	EMPLOYER ADDRESS:			EMPLOYER TELEPHONE NUMBER:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER	TELEPHONE NUMBER	EFFECTIVE DATE
MEDICAL				
PRESCRIPTION				
DENTAL				
VISION				

CHILD'S FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SON ☐ DAUGHTER ☐	STEP-CHILD ☐ ADOPTED ☐
CHILD'S ADDRESS IF DIFFERENT	CITY		STATE	ZIP CODE
STATE CHILD'S FULL-TIME/PART-TIME EMPLOYER:	EMPLOYER ADDRESS:			EMPLOYER TELEPHONE NUMBER:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER	TELEPHONE NUMBER	EFFECTIVE DATE
MEDICAL				
PRESCRIPTION				
DENTAL				
VISION				

CHILD'S FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SON ☐ DAUGHTER ☐	STEP-CHILD ☐ ADOPTED ☐
CHILD'S ADDRESS IF DIFFERENT	CITY		STATE	ZIP CODE
STATE CHILD'S FULL-TIME/PART-TIME EMPLOYER:	EMPLOYER ADDRESS:			EMPLOYER TELEPHONE NUMBER:

NAME OF COVERAGE	POLICY NUMBER	POLICY HOLDER	TELEPHONE NUMBER	EFFECTIVE DATE
MEDICAL				
PRESCRIPTION				
DENTAL				
VISION				

Local 464A United Food and Commercial Workers Union Welfare Service Benefit Fund
245 Paterson Avenue
Little Falls, NJ 07424
Telephone (973) 256-6790; Fax (973) 256-0399

NOTICE AND ACKNOWLEDGEMENT OF
TERMS OF COVERAGE UNDER THE WELFARE FUND

I, ____ hereby acknowledge and agree as follows, on
(PRINT YOUR FULL NAME)
behalf of myself and all of my eligible dependents covered by the Welfare Fund:

I am enrolling in coverage under the Local 464A United Food and Commercial Workers Union Welfare Service Benefit Fund ("the Welfare Fund"). I hereby declare that all statements and information I have provided to the Welfare Fund to enroll in coverage are true and complete to the best of my knowledge.

I understand and acknowledge that providing false information or omission of relevant information as part of the enrollment process may result in the denial of coverage. I further understand and acknowledge that I may be disqualified from coverage for a period of up to nine (9) months if I knowingly and with the intent to defraud, seek to obtain money or payment of a claim from the Welfare Fund by a misrepresentation of facts.

I further understand and acknowledge that:

- The Welfare Fund is not an insurance plan and is not governed by most state laws governing insurance, but instead is governed by the federal Employee Retirement Income and Securities Act, as amended ("ERISA").
- The Welfare Fund is strictly a reimbursement-only plan, and is payer of last resort. If I have any other source of payment for my medical expenses, whether through a private insurance policy, coverage through a spouse's employment, or otherwise (except Medicare), I must seek payment of the medical expense through that other source first. The Welfare Fund will pay the difference, if any, between the amount of the medical expense and the maximum amount payable from the other source of coverage, up to the maximum benefit provided under the terms of the Welfare Fund.
- The Welfare Fund does not cover medical expenses for which a third party is responsible to pay. This means that if I am in an accident or suffer injuries because of the fault of another person, I must look to that person for payment of my medical expenses. However, if in this situation I incur medical expenses that would otherwise be covered by the Welfare Fund, the Welfare Fund may advance payment on my behalf if I agree in writing to refund the Welfare Fund the full amount advanced on my behalf out of any recovery I receive from a third party or source responsible for payment.

I hereby agree to reimburse the Welfare Fund for medical expenses out of any monies I recover from any third party or other source of payment, whether by judgment, mediation, arbitration, settlement or otherwise, for injuries, illness or other harm sustained by me and for which the Welfare Fund has advanced medical expenses on my behalf. I hereby agree that if I obtain such a recovery from a third party, before any payment of money to me, a separate account will be established to reimburse the Welfare Fund.

I hereby grant to the Welfare Fund the equitable right to be made whole for the full extent of payments made by the Welfare Fund for injuries, illness or other harm sustained by me for which a third party or other source may be liable.

I hereby grant the Welfare Fund a first equitable lien in and subrogation rights to all monies payable to me by any third party who may be liable to me for any injuries, illness or other harm sustained by me, up to the full extent payment is made by the Welfare Fund. The equitable lien may be filed with third parties, their agents, insurers, guarantors, a court of competent jurisdiction, or my insurer.

I agree to cooperate fully and to do whatever is reasonably necessary to carry out the Welfare Fund's right to be made whole. I will notify the Welfare Fund when any legal action or settlement negotiations are commenced on my behalf; I will execute and deliver all requested documents; and I will provide the Welfare Fund with all requested information including information about claims, actions or administrative proceedings. I agree to do nothing, either before or after payment of benefits by the Welfare Fund, to waive, compromise, diminish, release or otherwise interfere with or prejudice the Welfare Fund's right to subrogation, reimbursement, and lien.

ACCEPTED AND APPROVED:

Member Signature Date

Spouse Signature Date

Adult Child Dependent Signature Date

Adult Child Dependent Signature Date

Adult Child Dependent Signature Date

Adult Child Dependent Signature Date

FOR OFFICE USE ONLY

Presented to {Name(s) of Member/Spouse/Adult Child} ____________________________

Date _________________________By____

(Rev. January, 2014)