

# Welfare Fund Benefits Office

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United Food & Commercial Workers Local 655  
13537 Barrett Parkway Drive, Suite 100  
Manchester, Missouri 63021  
(314) 835-2700 • Toll-Free (866) 565-2700 • Fax (314) 966-9848

Dear Plan Participant:

Provisions of the federal health care reform legislation (the Patient Protection and Affordable Care Act or “ACA”), allows you to enroll your dependent children under the age of 26 to your existing plan, with benefits beginning September 01, 2011. You can enroll your child, between the ages of 19 – 26 years, if you enroll them during this special 30 day enrollment period. The Fund Office must receive the enclosed form and a copy of your dependent’s birth certificate by August 31, 2011.

\*If you are currently purchasing a self-pay plan under our Early Retirement Incentive Program, or under COBRA, you may have a change in your premium if you are adding a child to your policy. Please contact the Fund Office regarding the amount of your premium

- **If you want to add dependents to your health plan who are between the ages of 19 - 26 years of age, you have a one-time special enrollment right under the law.** This enrollment right applies to adult children under 26 who were denied coverage in the past because they exceeded the maximum dependent age, or who were enrolled and lost coverage because they reached the maximum dependent age under the policy. The special enrollment period will run between August 01, 2011 – August 31, 2011.
- **If your child, over the age of 19, is already enrolled in the Plan as a full-time student,** the Fund will no longer require student verification, but you must complete the enclosed enrollment form to **continue** coverage for your adult child.
- **If you enroll your adult child, but want to cancel them at a later date,** you must contact the Fund Office within thirty-one (31) days of the date of cancelation.

**For your dependent child to be eligible for this coverage, your adult child DOES NOT have to be:**

- Financially dependent on you for support
- Claimed as dependents on your tax return
- Residents of your household
- To be enrolled as students
- Unmarried

“Qualified” dependents, such as grandchildren, are not eligible. “Children” includes natural born children, legally adopted children, stepchildren and children who are placed in your home for adoption.

Additional enrollment information may be requested from the Fund Office for adult children who have not been previously insured through the Fund. Please submit the Enrollment Form to the Fund Office as soon as possible along with a copy of your child’s birth certificate to avoid delay in your child’s benefits.

Please be aware that enrolling for coverage does not guarantee you qualify for coverage. Coverage is based on the average amount of hours worked as described in your Schedule of Benefits Grid. You can verify your eligibility by contacting the Fund Office at (314) 835-2700, toll-free (866) 565-2700, or checking your eligibility online at [www.655hw.org](http://www.655hw.org).

Sincerely,

The Board of Trustees  
UFCW Local 655 Welfare Fund

# CHILD ENROLLMENT ADD/CHANGE FORM

WELFARE FUND BENEFITS OFFICE • UFCW LOCAL 655

13537 Barrett Parkway Dr, Ste 100 – Manchester, MO 63021 – (314) 835-2700 (in St. Louis) or (866) 565-2700 (outside St. Louis)- Fax (314) 966-9848

**Instructions: To Elect Benefits for your Adult Child**, Please complete all applicable sections of this form and submit to the Fund Office along with a copy of your child's birth certificate.

**Return this form to the Fund office immediately.** The Fund office must receive your enrollment by **August 31, 2011** for you to enroll your adult child and yourself, if applicable, for coverage beginning September 1, 2011. **Fax the completed form to 314-966-9848 or mail to the Fund Office in the enclosed, self-addressed, return envelope.**

## I. Enrollment Election (Check the Appropriate Box)

**I Elect benefits for the following family members:** (Please mark your election)

- Employee only
- Employee & Spouse
- Employee and Child(ren)
- Employee and Family

## II. Participant Information:

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Policy Holder's ID No.: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Marital Status:  Single  Married Date \_\_\_/\_\_\_/\_\_\_  
 Divorced Date \_\_\_/\_\_\_/\_\_\_  Widowed Date \_\_\_/\_\_\_/\_\_\_

## III. Dependent Child Information: (If more than one dependent, please use back of form)

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Child's Full Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

- I am enclosing a **State-issued Copy** of the birth certificate.
- I am enclosing a Qualified Medical Child Support Order, a copy of the adoption papers or placement papers.
- This child has access to other health insurance coverage as follows:

Name and Relationship of Policy Holder: \_\_\_\_\_

Name of Insurance Company and phone number providing other coverage: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Coverage: (Check all that apply):  Medical  Hospital  Dental  Vision  Prescriptions  Mental Nervous/Substance Abuse

Type of Coverage:  Family  Individual Is coverage provided by an employer?:  Yes  No

## IV. Certification of True Statement and Payroll Deduction Authorization

I hereby apply for Health & Welfare benefits provided by UFCW Local 655 Welfare Fund for myself and for the eligible dependents listed on this form. I understand that I have made an election to enroll for benefits beginning September 1, 2011, as indicated on this Enrollment Form. Any choice I have made may only be altered as the result of a life-changing event. I declare for myself and/or my dependent(s) that I am eligible to enroll in this plan and request to be covered. I authorize my employer to deduct contributions from my pay. Should changes take place affecting these statements, I will immediately inform the Welfare Fund of the change. I hereby authorize any employer or insurance company to release any information, including medical history or treatment, that is necessary to determine benefits paid or payable concerning any claims related to the condition in question. I certify that the above information is true and correct. I understand that any intentional false statement made herein may void my coverage at the sole option of the Fund and will void the rights to benefits otherwise available to me and my dependents. In such an event, I agree to reimburse the Fund for any benefits received by me or my dependents to which we were not entitled.

Signature of Employee Electing Coverage

Date

**Dependent Child Information:**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Child's Full Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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Name and Relationship of Policy Holder: \_\_\_\_\_

Name of Insurance Company and phone number providing other coverage: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Coverage: (Check all that apply):  Medical  Hospital  Dental  Vision  Prescriptions  Mental Nervous/Substance Abuse

Type of Coverage:  Family  Individual Is coverage provided by an employer?:  Yes  No

**Dependent Child Information:**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Child's Full Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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Coverage: (Check all that apply):  Medical  Hospital  Dental  Vision  Prescriptions  Mental Nervous/Substance Abuse

Type of Coverage:  Family  Individual Is coverage provided by an employer?:  Yes  No