

# ANNUAL OPEN ENROLLMENT ELECTION

WELFARE FUND BENEFITS OFFICE • UFCW LOCAL 655

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

## Instructions:

**If you elect benefits**, sections I, II, III, IV, and V must be completed. If you are electing coverage on dependent children, please list them in section IV.

**Return this form to the Fund office immediately.**

**If you decline benefits**, check the appropriate box in section I, sign and date the form, and submit to the Fund office

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

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

- Employee only \$4.00 per week pre-tax deduction
- Employee & Spouse \$8.00 per week pre-tax deduction
- Employee and \*Child(ren) \$8.00 per week pre-tax deduction
- Employee and \*Family \$12.00 per week pre-tax deduction

\*Step-Children must live with the Employee to be eligible for enrollment

*Important Notice: Mid-year changes are not permissible, except in the case of a Life-Changing Event.*

*If an active enrollee is eligible for Medicare, the Fund is the primary insurance carrier, unless COBRA coverage is purchased.*

### • \*I decline all Health & Welfare benefits

\*I, \_\_\_\_\_, understand by declining coverage, I will not be eligible for benefits until the next annual open enrollment period, (unless a life changing event occurs). *(Signature below required)*

Signature of Employee Declining Coverage \_\_\_\_\_

Date \_\_\_\_\_

## II. Participant Information

Name: \_\_\_\_\_

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

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

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

Phone Number: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

## III. Spouse Information:

Spouse's Name: \_\_\_\_\_

Gender: • Male • Female Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security No.: \_\_\_\_\_

## IV. Print Name of Each Dependent Below (if electing dependent coverage)

	Last Name	First Name	Middle Initial	Birth Date	Social Security Number	Gender
Child-1	_____	_____	_____	___/___/___	_____	• Male • Female
Child-2	_____	_____	_____	___/___/___	_____	• Male • Female
Child-3	_____	_____	_____	___/___/___	_____	• Male • Female
Child-4	_____	_____	_____	___/___/___	_____	• Male • Female

## V. 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 for the Plan Year 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.

Signature of Employee Electing Coverage \_\_\_\_\_

Date \_\_\_\_\_