

ENROLLMENT CHANGE FORM

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)

Instructions:

If you have experienced a life changing event which allows you to modify your original enrollment election, please complete this form and submit any documentation needed to the Fund Office within 31 days of the event.

If you elect benefits, sections I, II, III, IV, and V must be completed and signed and returned to the Fund office.

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:

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

*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
(Print name of employee)
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: _____
Last Name First Name Middle Initial

Policy Holder's ID No. or Social Security No.: _____ Gender: • Male • Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Birth Date: ____ / ____ / ____
Month Day Year

III. Spouse Information:

Spouse's Name: _____
Last Name First Name Middle Initial

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
Child-5	_____	_____	____ / ____ / ____	_____	• 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