

**UFCW • LOCAL 655 • WELFARE FUND**  
 13537 Barrett Parkway Drive Suite 100 • Manchester, Missouri 63021  
 Health & Welfare Fund • 314-835-2700 • 1-866-565-2700

# ENROLLMENT FORM



Please Complete The Following:

Members Social Security # \_\_\_\_\_

Local Union Affiliation     655     881     534     700

|                         |                             |   |
|-------------------------|-----------------------------|---|
| <b>1</b> Insured's Name | Spouse's Name               | Employed Child's Name (Use a separate sheet if more than one covered child is employed) |
| Insured's Date of Birth | Spouse's Date of Birth      | Child's Date of Birth   |
| Insured's Employer      | Spouse's Employer           | Child's Employer  |
| Employer's Address      | Spouse's Employer's Address | Child's Employer's Address  |
| Employer's Phone #      | Spouse's Employer's Phone # | Child's Employer's Phone #  |

|   |   |  |
|---|---|--|
| <b>2</b> Does Any Family Member Have Any Other Group Health Benefits Program? | <input type="checkbox"/> Yes If Yes, Please Complete Next Three Lines.  |  |
|   | <input type="checkbox"/> No If No, But Patient Did Have A Coverage That Ended, Give Date Ended: ___/___/___ (MO/DA/YR) & Complete next 3 lines OR submit copy of term letter. |  |
| Name Of Policy Holder   | Relationship To Patient   | Policy Holder's Social Security #  |
| Policy #  | Effective Date Of Policy  | Type Of Coverage Under Policy<br><input type="checkbox"/> Individual <input type="checkbox"/> Family |
| Name & Phone # Of Insurance Company Providing Other Coverage                  | Coverage's (Circle All That Apply)<br>1-Medical    2-Hospital    3-Dental    4-Vision    5-Mental Condition    6-Prescription Drugs   |  |

|  |   |   |
|--|---|---|
| <b>3</b> Is The Family Member Eligible For Medicare    Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No    Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Please Provide: |   |   |
| Effective Date<br>Part A ___/___/___ (MO/DA/YR)    Part B ___/___/___ (MO/DA/YR)   | Cancellation Date<br>Part A ___/___/___ (MO/DA/YR)    Part B ___/___/___ (MO/DA/YR) | Subscriber's Name<br>Subscriber's Social Security # |

|  |                                     |                       |
|--|-------------------------------------|-----------------------|
| <b>4</b> Is Any Family Member A Dependent Child? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Please Complete The Rest Of This Section. (If Other Dependent Children Are Covered Under Your Program, Also Provide The Following Information For Each Child. Use Separate Page.) |                                     |                       |
| Natural Father's Name & Birthdate  | Natural Mother's Name & Birthdate   |                       |
| Natural Father's Employer & Phone #  | Natural Mother's Employer & Phone # |                       |
| Employer's Address, City & Zip Code  | Employer's Address, City & Zip Code |                       |
| Are The Natural parents Divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Give Name And Address Of Parent Who Has Custody Of Patient.  |                                     |                       |
| Have You Sent A Copy Of Your Divorce Decree To The Fund Office ? <input type="checkbox"/> Yes <input type="checkbox"/> No    If No, Please Attach A Copy To Questionnaire.   |                                     |                       |
| Has A Court Stated That One Parent Should Pay For Medical Bills? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, Please Provide The Following:   |                                     |                       |
| Name And Address Of Parent Responsible For Medical Bills   | Parents Social Security #           |                       |
| Name And Address Of Insurance Company Of Parent Responsible For Medical Bills  | Policy #                            | Policy Effective Date |

I HEREBY AUTHORIZE ANY EMPLOYER, INSURANCE COMPANY, ANY INFORMATION, INCLUDING MEDICAL HISTORY OR TREATMENT THAT IS NECESSARY TO DETERMINE BENEFITS PAID OR PAYABLE CONCERNING THIS CLAIM OR OTHER CLAIMS RELATED TO THIS CONDITION. 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 AND WILL VOID THE RIGHTS TO BENEFITS OTHERWISE AVAILABLE TO ME AND MY DEPENDENTS. IN SUCH EVENT, I AGREE TO REIMBURSE FOR ANY BENEFITS RECEIVED BY ME OR MY DEPENDENTS TO WHICH WE WERE NOT ENTITLED.

\_\_\_\_\_  
**Signature Of Insured Plan Participant**

\_\_\_\_\_  
**Date**

Continued on back side

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|   |                                  |   |  |  |                   |
|---|----------------------------------|---|--|--|-------------------|
| Enrollment Form For:  |                                  |   |  |  |                   |
| <input type="checkbox"/> New Member <input type="checkbox"/> Add Spouse <input type="checkbox"/> Drop Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Update |                                  |   |  |  |                   |
| Name Of Member  |                                  |   |  |  | Social Security # |
| Member's Address, City, State & Zip Code  |                                  |   |  |  |                   |
| Member's Date Of Birth<br>____/____/____ (MO/DA/YR)   |                                  |   | Member's Phone #   |  |                   |
| <input type="checkbox"/> Male   | <input type="checkbox"/> Single  | <input type="checkbox"/> Divorced                                   | <input type="checkbox"/> Date Of Divorce ____/____/____ (MO/DA/YR) |  |                   |
| <input type="checkbox"/> Female   | <input type="checkbox"/> Married | <input type="checkbox"/> Date Of Marriage ____/____/____ (MO/DA/YR) | <input type="checkbox"/> Widowed                                   | <input type="checkbox"/> Date Of Death ____/____/____ (MO/DA/YR) |                   |
| Employer's Name   |                                  |   |  | Date Of Hire<br>____/____/____ (MO/DA/YR)                        |                   |

**Important Information** – Please List Life Insurance Beneficiary (Someone Other Than Yourself).

|  |  |                             |  |
|--|--|-----------------------------|--|
| Name Of Life Insurance Beneficiary – First, Middle Initial, Last |  | Relationship Of Beneficiary |  |
| Beneficiary's Address, City, State & Zip Code                    |  | Beneficiary's Phone #       |  |

Print Name Of Each Dependent Below. Dependents To Be Listed Are Legal Spouse, All Unmarried Children Under Age 23 Years Of Age. All Eligible Dependents Must Be Listed.

| List Names Of Eligible Dependents<br>(Spouse First) | SOCIAL SECURITY # | DATE OF BIRTH |     |      | RELATIONSHIP |     |          |
|---|-------------------|---------------|-----|------|--------------|-----|----------|
|   |                   | Month         | Day | Year | Spouse       | Son | Daughter |
| 1.  |                   |               |     |      |              |     |          |
| 2.  |                   |               |     |      |              |     |          |
| 3.  |                   |               |     |      |              |     |          |
| 4.  |                   |               |     |      |              |     |          |
| 5.  |                   |               |     |      |              |     |          |
| 6.  |                   |               |     |      |              |     |          |
| 7.  |                   |               |     |      |              |     |          |
| 8.  |                   |               |     |      |              |     |          |

"I HEREBY CERTIFY THAT THE ABOVE INFORMATION REGARDING MY DEPENDENTS AND MARITAL STATUS IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE."

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**