ALASKA U.F.C.W. HEALTH AND WELFARE AND PENSION TRUSTS

ENROLLMENT/DECLINATION OF COVERAGE/BENEFICIARY/DEPENDENT COVERAGE AUTHORIZATION FORM **F45**

ANSWER ALL QUESTIONS & RETURN IMMEDIATELY

PURPOSE FOR COMPLETING FORM: ☐ Annual Enrollment ☐ New Employee ☐ Beneficiary Change
☐ Addition of Dependents ☐ Address Change ☐ Name Change _____ ☐ Other _____
Previous Name

PAYROLL DEDUCTION AUTHORIZATION: I authorize a weekly payroll deduction by my employer for health coverage for myself and/or my eligible dependents. You must check one of the following boxes to confirm who you will cover (or decline coverage):
☐ Employee Only; ☐ Employee + Child(ren); ☐ Employee + Spouse and/or Family;
☐ I Decline Coverage Until Next Open Enrollment

***A SPOUSE WHO IS ELIGIBLE FOR COVERAGE THROUGH HIS OR HER OWN EMPLOYER IS DISQUALIFIED FROM COVERAGE UNDER THIS PLAN IF HE OR SHE HAS NOT ELECTED/ACCEPTED SUCH COVERAGE.**

Important Note: If you do not enroll your eligible dependents for coverage at this time, you will not be able to do so until the next annual Open Enrollment, unless you have a qualifying change in family status. Failure to complete and return this form will cause loss of health plan eligibility.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Month/Day/Year)	RELATIONSHIP TO MEMBER
Member/Employee				Self
Mailing Address (Street, City, State, Zip Code)				
Phone Number		**E-mail Address**		
Spouse* You must check the box above for weekly payroll deduction				**Date of Marriage:**
Dependent Children* You must check the box above for weekly payroll deduction				

If you enroll a spouse and/or children, you must provide supporting documentation such as a marriage certificate or birth certificates.

OTHER INSURANCE INFORMATION – **YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by or eligible to enroll in any other group medical insurance plan including Alaska UFCW, Medicaid and/or Medicare? YES ☐ NO ☐ ***If "YES," please provide the information requested below. If "NO," please go to #3 below.***

Name of Subscriber with Other Coverage **Subscriber Social Security Number**

Name and Address of Other Insurance Company **City** **State** **Zip**

Policy or ID Number: If Medicare, copy of Medicare ID must be on file with the Administration Office.

2. Other insurance covers: Employee ☐ Spouse ☐ Children ☐ Date Coverage Began: _____
3. Is your spouse employed? YES ☐ NO ☐ If yes, list employer: _____
4. Does spouse's employer provide access to group health insurance? YES ☐ NO ☐
5. If yes, was that coverage declined? YES ☐ NO ☐ Or accepted? YES ☐ NO ☐

HEALTH & WELFARE/PENSION BENEFICIARY DESIGNATION

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Pension Plan Document or Health and Welfare Plan Document.

Beneficiary Name _____ _____
Last **First** **Social Security Number**

Beneficiary Address _____

Unless otherwise noted, if two or more beneficiaries are named, proceeds shall be paid in equal shares to the above beneficiaries.

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below. I hereby expressly acknowledge that false information given to an employee benefit plan is a crime and a violation of AS 21.36.360.

Date: _____ _____
Participant Signature ***(must be signed by participating employee)***

RETURN WHITE COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203

Alaska UFCW Health and Welfare Trust
Annual Open Enrollment

Instructions for Completing Annual Enrollment Form:

1. Check the appropriate box(es) in the "Purpose for Completing Form" box.

   A. If you are an employee electing coverage, check the "Annual Enrollment" box.

   B. If you wish to add dependent child(ren) and/or spouse, check the "Addition of Dependents" box. *You will need to provide supporting documentation for your dependents, such as a marriage certificate for your spouse or birth certificates for children.*

   C. If you have a new address, name change, or wish to make other changes, check the appropriate boxes.

2. Check the appropriate box for the weekly payroll deduction you authorize: Employee Only; Employee + Child(ren); or Employee + Spouse and/or Family. Or if you are declining coverage, check the I Decline Coverage Until Next Open Enrollment box.

   ***Note*: Members are typically not eligible to cover their spouse in their first twenty-four (24) months of eligibility, unless the member has completed 1200 hours of employment. Contact the Administration Office for more information.**

   A spouse who has health coverage available through his or her employer but does not elect or accept such coverage is disqualified from coverage under this Plan.

   If your spouse is not enrolled and you do not complete the Enrollment Form to add him or her to your coverage at this time, you will not be able to do so until the next annual Open Enrollment, unless your spouse loses other group coverage due to certain circumstances, such as termination of employment, reduction of hours, exhaustion of COBRA continuation coverage, etc.

3. Complete the next section with your name and social security number. Write in the names of all dependents who will be covered by the Plan (i.e., yourself, your spouse, your children, etc.). Be sure to indicate your current address and telephone number.

4. Complete the next section to show if you have any *other* group medical coverage for yourself, your spouse, and/or children.

5. Designate a beneficiary to receive the proceeds of your Health and Welfare and Pension Death Benefits.

6. Sign and date the Enrollment Form. Keep the **yellow copy** for your records. Return the **white copy** to the Administration Office along with any supporting documentation for your dependents, such as a marriage certificate for your spouse or birth certificates for children, in the envelope provided by **December 21, 2020.** You may also fax your completed Enrollment Form and supporting documentation to (907) 561-4802, or scan and e-mail to AKUFCWforms@wpas-inc.com.

***Important Note*: Failure to complete and return this form will cause loss of health plan eligibility for you and your dependents. If all required information is not provided, the Enrollment Form will be returned to you for completion.**

Administration Office
Alaska UFCW Health and Welfare Trust