UFCW Local 1000 Oklahoma
Health & Welfare Fund
"CARE-1000"

2010 N.W. 150th Avenue, Suite 100 • Pembroke Pines, FL 33028
(800) 842-5899 • Fax (954) 266-2079

Welcome to the UFCW Local 1000 Oklahoma Health & Welfare Fund, also called "CARE-1000". Your eligibility for the UltraCare-1000 plan is determined based upon the length of time you have been an employee, the hours you work and/or your designation as a Full Time or Variable Hour employee by your employer. We encourage you to refer to the Summary Plan Description and Benefits Program booklet to learn how your plan works.

The Summary Plan Description and Benefits Program booklet explain how you can become eligible for coverage and what is covered by the Plan.

In order to enroll in the Plan, you must complete these enrollment materials. You must also agree to make a weekly contribution towards your coverage, which will be deducted from your payroll check. If you don't enroll, you will not have coverage under the plan. You will only be offered the opportunity to enroll under limited circumstances, so it is very important that you complete and return the materials timely.

If you need assistance completing the forms, please call the Fund Office at 1 (877) 602-2733 Monday – Friday between the hours of 7 a.m. – 4 p.m. Central Time.

1. First, tell us about yourself.

First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SS#	
Address					
City		State		Zip Code	
Marital Status		Hire Date		Store #	

2. If we need to get in touch with you, what do you prefer?

Please mark your preferred method.

☐	**Call me**	**Phone Number: ( ) -**
☐	**Email me**	**Email Address:**
☐	**Send me mail via the U.S. Postal Service to the address I listed above.**	

3. Do you want to enroll for coverage under the Plan?

If you qualify for UltraCare-1000 you have the option to enroll for employee only coverage or employee and dependent child(ren) coverage. **Please choose one of the options below.**

☐	**YES, enroll me for employee only coverage. The amount of the required contribution is $5.00 per week.**	I request coverage under the UFCW Local 1000 Oklahoma Health & Welfare Fund and I authorize my Employer to deduct any required contributions from my earnings. I understand that this election cannot be changed during the Plan year, unless the revocation and new election are on account of and consistent with a change in dependent status (i.e. marriage or birth of a child). I understand that this election form shall replace and supersede any previous requests for coverage and/or designation of beneficiary. **I understand that my benefits terminate on the date my employment with the company is terminated.** **Signature: _____ Date: _____**
☐	**YES, enroll me & my eligible dependent children. The amount of the required contribution for employee and dependent children coverage is $15.00 per week.**	
☐	**NO, do not enroll me.**	**I understand that I will only be permitted to enroll in the plan at Open Enrollment time, unless I experience a qualifying event, such as the loss of other group health coverage, marriage, etc.** **I understand that by declining coverage, I am waiving all benefits to which I am entitled, including medical, dental, life insurance, prescription drug coverage and weekly accident and sickness benefits.** **Signature: _____ Date: _____**

4. Would you like to purchase additional life insurance coverage?

You have the option to purchase additional life insurance coverage for UltraCare-1000. If you elect the additional coverage, the value of your life insurance benefit under UltraCare-1000 will double. See Benefits Program booklet for more details. If no election is made, "NO" will be elected on your behalf.

☐	**YES, I would like to purchase additional coverage. The amount of the required contribution is $1.50 per week.**	I request the additional coverage under the UFCW Local 1000 Oklahoma Health & Welfare Fund and I authorize my Employer to deduct any required contributions from my earnings. I understand that this election cannot be changed during the Plan year, unless the revocation and new election are on account of and consistent with a change in dependent status (i.e. marriage or birth of a child). I understand that this election form shall replace and supersede any previous requests for coverage and/or designation of beneficiary. **I understand that my benefits terminate on the date my employment with the company is terminated.** Signature: _____ Date: _____
☐	**NO, I would not like to purchase additional coverage.**	Signature: _____ Date: _____

5. What doctor in the United Healthcare PPO Network will provide your primary care?

You are not required to name a Primary Care Physician (PCP), but you are encouraged to do so. It's important to name a Primary Care Physician before you get sick! If you don't, it can be difficult to get an appointment when you need one. Visit www.uhss.welcometouhc.com ***to locate in-network providers.***

Physician Name:	**Physician Address:**
Physician Phone Number:	

6. Are you enrolling dependent children? If so, please provide their information below, tell us if they have other insurance and name their Primary Care Physician (PCP).

To enroll your dependent children you will need to provide copies of their social security cards and birth certificates. To add dependent children please fill out their information below and submit the required documents to the Fund Office via fax, mail or through the Fund Website www.nebainc.com/care1000 within 15 days. Dependent children will not be enrolled in the plan if the documentation is not submitted timely.

Dependent Name	SS # /Date of Birth/Ins.	Relationship	Primary Care Physician (PCP)
	SS# _ _ _-_ _-_ _ _ _ D.O.B _ _/_ _/_ _ Other Insurance? **Y or N**		PCP Name:____________________________ Address:______________________________ Phone #:______________________________

Dependent Name	SS # /Date of Birth/Ins.	Relationship	Primary Care Physician (PCP)
	SS# _ _ _-_ _-_ _ _ _ D.O.B _ _/_ _/_ _ Other Insurance? **Y or N**		PCP Name:____________________________ Address:______________________________ Phone #:______________________________

Dependent Name	SS # /Date of Birth/Ins.	Relationship	Primary Care Physician (PCP)
	SS# _ _ _-_ _-_ _ _ _ D.O.B _ _/_ _/_ _ Other Insurance? **Y or N**		PCP Name:____________________________ Address:______________________________ Phone #:______________________________

Dependent Name	SS # /Date of Birth/Ins.	Relationship	Primary Care Physician (PCP)
	SS# _ _ _-_ _-_ _ _ _ D.O.B _ _/_ _/_ _ Other Insurance? **Y or N**		PCP Name:____________________________ Address:______________________________ Phone #:______________________________

7. Last, name your beneficiary.

In the event of your death, your named beneficiary will receive the life insurance benefits you qualify for. If you wish to list more than one beneficiary, please tell us what percentage of your benefit you wish to assign to each person. <u>The total of the percentages must equal 100%.</u>

	Beneficiary 1	%	Beneficiary 2	%
Name:		*%*		*%*
SSN:				
Address: *City, State & Zip:*				
Date of Birth:				
Relationship:				
Telephone Number:				

Contingent Beneficiary

(If your Primary Beneficiaries are deceased)

	Contingent Beneficiary 1	%	Contingent Beneficiary 2	%
Name:		*%*		*%*
SSN:				
Address: *City, State & Zip:*				
Date Of Birth:				
Relationship:				
Telephone Number:				

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