ALASKA UFCW HEALTH AND PENSION TRUSTS

ADMINISTERED BY ZENITH AMERICAN SOLUTIONS
12205 SW TUALATIN ROAD, SUITE 200 TUALATIN, OR 97062
ELECTION OF COVERAGE & BENEFICIARY DESIGNATION FORM

REASON 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 Am A Non-Bargaining Associate Employee; ☐ 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. If additional space is required to list your covered dependents, please check box and list on back of page. ADDITIONAL DEPENDENTS LISTED ON BACK ☐

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Month/Day/Year)	RELATIONSHIP TO PARTICIPANT
Participant/Employee				Self
Mailing Address (Street, City, State, Zip Code)				
E-mail Address		**Phone Number**		
Employer Name		**Employer Location**		
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 to verify dependent status 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)***

PLEASE RETAIN A COPY OF YOUR COMPLETED FORM AND RETURN THE ORIGNAL TO YOUR EMPLOYER.
YOUR EMPLOYER WILL SUBMIT YOUR FORM TO LOCAL 1496 AND THE TRUST OFFICE FOR PROCESSING.
AK-UFCW-ELIGIBILITY@Zenith-American.com