

Southern California Drug Benefit Fund

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www.ufcwdrugtrust.org



OPEN ENROLLMENT RESPONSE FORM

ALL GOLD AND PLATINUM PARTICIPANTS

IMMEDIATE RESPONSE REQUIRED

You must enroll yourself and your Dependents and authorize payment of your monthly Employee Contribution by completing and returning this Enrollment Response Form and the Authorization for Employer Deduction on the reverse side. You must do this NOW in order to receive benefits from the Southern California Drug Benefit Fund after February 29, 2012. If you do not return this Form and the Authorization your coverage will **TERMINATE EFFECTIVE March 1, 2012**. NOTE: If you return this form after January 15th the Drug Fund will advise you in writing whether or not your Authorization will be accepted. Open Enrollment Plan changes will not be allowed after January 15th.

1. PARTICIPANT INFORMATION (please print and use blue or black ink)

Last Name		First Name		Mid. Initial	Social Security Number	
Mailing Address Street:		<input type="checkbox"/> Check if address is new.	City	State	ZIP code	Date of Birth (mm/dd/yyyy)
Home phone ()		<input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Marriage or Partnership (mm/dd/yyyy)		<input type="checkbox"/> Divorced
Mobile phone ()		<input type="checkbox"/> Domestic Partner				<input type="checkbox"/> Widowed
Employer	Store #	Work Phone ()	Date of Hire (mm/dd/yyyy)	Job Title	Union Local	

2. EMPLOYEE CONTRIBUTION AMOUNT & ENROLLMENT

(CHECK ONE BELOW AND LIST YOURSELF AND EACH DEPENDENT YOU WISH TO ENROLL FOR COVERAGE).

<input type="checkbox"/> Myself Only \$7.00 / week \$30.33 / month	<input type="checkbox"/> Myself and One or More Children \$11.00 / week \$47.67 / month	<input type="checkbox"/> Myself and My Spouse (or Domestic Partner), with or without Children \$15 / week \$65.00 / month <small>(If no children cost is still \$65.00)</small>
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I elect coverage for myself and my Dependents listed below. I understand that beginning March 1, 2012 I will be required to pay the applicable monthly Employee Contribution amount (shown above) that is required to maintain coverage for myself and my family. NOTE: In order to enroll yourself and your eligible Dependents, you must complete the information in this item 2 for yourself and each Dependent. A Marriage Certificate is required (if adding spouse) and Birth Certificates are required for newly enrolled Dependent Children.

Participant	SSN (required)	Gender (M/F)	Date of Birth
Spouse / Domestic Partner	SSN (required)	Gender (M/F)	Date of Birth
Child	SSN (required)	Gender (M/F)	Date of Birth
Child	SSN (required)	Gender (M/F)	Date of Birth
Child	SSN (required)	Gender (M/F)	Date of Birth
Child	SSN (required)	Gender (M/F)	Date of Birth
Child	SSN (required)	Gender (M/F)	Date of Birth

Note: To include more Children, please attach a separate sheet of paper.

3. PLAN SELECTION (PLAN CHANGES ARE ALLOWED ONLY DURING THE OPEN ENROLLMENT PERIOD OR IF THERE IS A SPECIAL ENROLLMENT RIGHT)

<input type="checkbox"/> I WISH TO REMAIN IN MY CURRENT MEDICAL PLAN	<input type="checkbox"/> I WISH TO REMAIN IN MY CURRENT DENTAL PLAN.
I WISH TO CHANGE TO THE FOLLOWING MEDICAL PLAN: <small>(Kaiser and United HealthCare are available to those with a Hire Date on or before January 1, 2009.)</small> <input type="checkbox"/> INDEMNITY MEDICAL PLAN (Anthem Blue Cross Prudent Buyer) <input type="checkbox"/> KAISER PERMANENTE DEDUCTIBLE HMO <input type="checkbox"/> UNITED HEALTHCARE (UHC) FLEX HMO	I WISH TO CHANGE TO THE FOLLOWING DENTAL PLAN: <input type="checkbox"/> INDEMNITY DENTAL PLAN (through Delta Dental of California) <input type="checkbox"/> UNITED CONCORDIA PRE-PAID DENTAL PLAN

Please see enclosed Summary of Benefits for Plan Information. A separate Enrollment packet will be sent to you if you elect a Plan Change to Kaiser or United HealthCare above. Plan changes are effective January 1, 2012.

4. OTHER COVERAGE (It is your responsibility to notify the Fund Office in writing when you or your dependents obtain other coverage, including Medicare.)

Is other coverage available to you through another group health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Under Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your spouse (or domestic partner) under another group health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Under Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Name of Other Insurance Company Plan/Employer	Name of Insured
Is other coverage available to your Child(ren) under another group health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Under Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Name of Other Insurance Company Plan/Employer	Name of Insured

5. AUTHORIZATION AND VERIFICATION

I hereby elect coverage for myself and my eligible dependents as indicated on this form and certify that the information provided on this form is complete and correct. To the extent consistent with applicable law, I hereby authorize any medical or dental provider or other health care practitioner, hospital or other institution to furnish to the Southern California Drug Benefit Fund any information required to process claims for me and my covered family members. I also authorize the Fund, its agents, designees, and representatives to disclose to any medical or dental provider, any medical or dental information required to process any claim. I understand that any dispute or controversy which may arise between me (and/or any family member enrolled hereunder) and any HMO or Prepaid Dental Plan office must be submitted to binding arbitration in lieu of a jury or court trial. I understand that completing this form does not guarantee eligibility for benefits, and that I must first establish eligibility and maintain eligibility for benefits in accordance with the rules of the Plan.

Participant Signature (unsigned forms will be returned for signature)

Date

SOUTHERN CALIFORNIA DRUG BENEFIT FUND AUTHORIZATION FOR PAYROLL DEDUCTION

THIS FORM MUST BE COMPLETED AND RETURNED TO THE DRUG TRUST FUND OFFICE TO AUTHORIZE YOUR EMPLOYER TO DEDUCT YOUR MONTHLY EMPLOYEE CONTRIBUTION FROM YOUR PAYCHECK

- Effective MARCH 1, 2012, all Gold and Platinum Participants of the Southern California Drug Benefit Fund will be required to pay a monthly Employee Contribution to participate and to receive benefits provided by the Southern California Drug Benefit Fund. Employee Contributions must be made in advance of the month of coverage. So, for example, Employee Contributions paid in March 2012 are for April 2012 coverage.
- You must complete this Form and return it to the Drug Fund Office** to authorize your Employer to deduct your Employee Contribution from your paycheck. The amount of your monthly Employee Contribution depends on which family members you enroll, and is shown on the reverse side of this form. Please note that payroll deductions of Employee Contributions will be taken in advance of the month of coverage and will continue each month until you later reject coverage in writing. However, if you fail to work "Qualifying Hours" you will not be eligible for benefits and your Employee Contribution will not be deducted for any month in which you fail to work "Qualifying Hours".
- Please note:** If your Employer is unable to deduct the monthly Employee Contribution from your paycheck, your coverage will terminate and the Drug Fund will bill you for the required monthly Employee Contribution. You will then be required to pay the amount indicated on the bill. If you do not pay the required Contribution by the due date, coverage will remain terminated and you will not be able to re-enroll in coverage until the next Open Enrollment Period, unless you or a Dependent have a special enrollment right.

Authorization For Payroll Deduction for Employee Premium Contribution

I authorize my Employer to withhold the monthly amount of \$_____ (as noted on the reverse side) from my paycheck and to remit the payment directly to the So. CA Drug Benefit Fund. I understand that if my Employer cannot deduct this amount from my paycheck, I will be billed for the Employee Contribution amount, and that it is my responsibility to make payment to the So. CA Drug Benefit Fund by the due date indicated on the bill.

I understand that, in order to maintain my coverage, I must continue to satisfy the Drug Fund's eligibility rules by working the required "Qualifying Hours" and I must pay a monthly Employee Contribution.

PLEASE PRINT CLEARLY

Name (Last)		(First)		M.I.	Union Local
Social Security Number 		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number	
Mailing Address (Street)		(City)		(State)	(Zip)
Employer	Store #	Date of Hire	Job Title	Work Phone Number	

IMPORTANT: YOUR SIGNATURE IS REQUIRED BELOW TO AUTHORIZE AN EMPLOYEE CONTRIBUTION DEDUCTION FROM YOUR PAYCHECK. YOU MUST COMPLETE AND RETURN THIS AUTHORIZATION TO THE SO. CA DRUG BENEFIT FUND, P.O. BOX 27920, LOS ANGELES, CA 90027

Signature:	Date:
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INCOMPLETE FORMS WILL BE RETURNED TO YOU

OFFICE USE ONLY

_____ /_____/_____
 Entered by Date Eff Date Sent to Employer Deduct Amnt Self Pay