Return this form ONLY if you are making changes to your current coverage

Southern California Drug Benefit Fund
P. O. Box 27920, Los Angeles, CA 90027
Phone: (323) 666-8910
Toll Free: (877) 999-8329
Fax: (323) 913-0484
www.ufcwdrugtrust.org

ENROLLMENT FORM

GOLD AND PLATINUM PARTICIPANTS

Check all that apply:

☐ New Hire/Initial Enrollment ☐ Change of Address ☐ Add/Delete Dependents ☐ Change Plan(s) ☐ Transfer

(If married, New Hires must submit proof of marriage)

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

Last Name	First Name	Middle Initial	Sex M/F	Social Security Number

Mailing Address ☐ Check if address is new. Street:	City	State	ZIP code	Date of Birth (mm/dd/yyyy)

Home phone ( ) / Mobile phone ( )	☐ Single ☐ Married ☐ Domestic Partnership	Date of Marriage or Partnership: *(attach proof of marriage/domestic partnership)*	☐ Divorced ☐ Widowed

Employer	Store #	Work Phone ( )	Date of Hire (mm/dd/yyyy)	Job Title	Employee ID	Union Local

2. REJECT COVERAGE

☐ **I want to reject coverage for myself and all of my enrolled dependents and stop payroll deductions as indicated by my signature below in #6.** I understand that I will not be allowed to re-elect coverage until the next Open Enrollment, unless a Special Enrollment right exists.

3. EMPLOYEE CONTRIBUTION AMOUNT & ENROLLMENT - CHECK ONE BELOW AND LIST EACH DEPENDENT YOU WISH TO ENROLL (OR DISENROLL). THIS FORM WILL REPLACE ANY PREVIOUS ENROLLMENT FORM YOU MAY HAVE SUBMITTED.

☐ Myself Only	☐ Myself and One or More Children	☐ Myself and My Spouse (or Domestic Partner), with or without Child(ren)
$8.00 / week **$34.67 / month**	$12.00 / week **$52.00 / month**	$16 / week **$69.33 / month** (If no children, cost is still $69.33/month)

I wish to enroll (or disenroll) the Dependents listed below. I understand that 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. I understand that in order to enroll my eligible Dependents, I must list them below and I must submit a copy of my Marriage Certificate/proof of Domestic Partnership (if enrolling spouse/domestic partner) and copies of Birth Certificates for newly enrolled Dependent Children.

Spouse / Domestic Partner	SSN or TIN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll
Child	SSN (required)	Sex (M/F)	Date of Birth	☐ Enroll ☐ Disenroll

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

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

☐ **I WISH TO REMAIN IN MY CURRENT MEDICAL PLAN**

☐ **I WISH TO REMAIN IN MY CURRENT DENTAL PLAN.**

I ELECT THE FOLLOWING MEDICAL PLAN:

* New hires are required to enroll in the Indemnity Medical Plan. An HMO is available beginning the 4th annual Open Enrollment after your date of hire.

☐ **INDEMNITY MEDICAL PLAN** (Anthem Blue Cross Prudent Buyer)

☐ *** KAISER PERMANENTE DEDUCTIBLE HMO**

☐ *** UNITED HEALTHCARE (UHC) HMO**

I ELECT THE FOLLOWING DENTAL PLAN:

☐ **INDEMNITY DENTAL PLAN** (through Delta Dental of California)

☐ **UNITED CONCORDIA PREPAID DENTAL PLAN**

5. OTHER COVERAGE - It is your responsibility to notify the Fund Office in writing when you or your Dependents obtain other coverage including Medicare.

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

6. 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 (the "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 if I have elected coverage under the Kaiser or UHC HMO or under the United Concordia Prepaid Dental Plan, the Fund will mail me an enrollment form for each HMO that I have selected, and I must complete and return the enrollment form for each HMO in order to have coverage. 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 (Employee) 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 FUND OFFICE TO AUTHORIZE YOUR EMPLOYER TO DEDUCT THE REQUIRED AMOUNT OF THE MONTHLY EMPLOYEE CONTRIBUTION FROM YOUR PAYCHECK

1. All Gold and Platinum Participants in the Southern California Drug Benefit Fund (the "Fund") are required to pay a monthly Employee Contribution to participate in and to receive Fund benefits. Employee Contributions must be made in advance of the month of coverage. So, for example, the monthly Employee Contribution deducted (at the appropriate weekly rate) from your paycheck(s) in February 2022 and paid to the Fund in March 2022 is for April 2022 coverage. **Therefore, if you do not already have coverage from the Fund, you should submit payment for two months of Employee Contributions with your completed Enrollment Form.**

2. **You must complete this Authorization form and return it to the Fund Office** to authorize your Employer to deduct your Employee Contribution from your paychecks. 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 the monthly Employee Contributions will be taken in advance of the month of coverage and will continue each month until you later reject coverage in writing.

Authorization For Payroll Deduction for Employee Premium Contribution

I authorize my Employer to withhold from my paycheck the weekly premium amount required to maintain the level of benefits selected on the reverse side, currently:

☐ **$8.00 per week ($34.67/month)**

☐ **$12.00 per week ($52.00 / month)**

☐ **$16.00 per week ($69.33 / month)**

and to pay these amounts directly to the So. CA Drug Benefit Fund. I understand that if my Employer does not deduct the appropriate amount from my paychecks, I will be billed for whatever portion of the monthly Employee Contribution amount is owed, and that it is my responsibility to make full payment to the So. CA Drug Benefit Fund by the due date indicated on the bill, or I will lose coverage.

In addition to the above, in the event there is a change to the amount of the monthly Employee Contribution required to maintain the coverage that I selected, this authorization will remain in effect, and my Employer is authorized to deduct the amount necessary to maintain the coverage that I selected. I understand that the Fund Office will give me at least 30 days advance written notice of any change to the monthly Employee Contribution required for my coverage, and that I may revoke this authorization and reject coverage at any time by completing the appropriate form and delivering it to the Fund Office.

I further understand that, in order to maintain my coverage, I must continue to satisfy the Fund's eligibility rules by working the required "Qualifying Hours" and paying the required Employee Contributions.

IMPORTANT: YOUR SIGNATURE IS REQUIRED BELOW TO AUTHORIZE PAYROLL DEDUCTIONS.

PLEASE PRINT CLEARLY

Employee Name (Last)	(First)	M.I.	Union Local

Social Security Number or TIN Number	Date of Birth	☐ Male ☐ Female **Must check one**	Home Phone Number
| | | | | | | |			

Mailing Address (Street)	(City)	(State)	(Zip)

Employer	Store #	Date of Hire	Job Title	Work Phone Number

IMPORTANT: BY SIGNING BELOW, I AUTHORIZE MY EMPLOYER TO DEDUCT MY EMPLOYEE PREMIUM CONTRIBUTION FROM MY PAYCHECK AND PAY IT TO THE SOUTHERN CALIFORNIA DRUG BENEFIT FUND AS DESCRIBED ABOVE.

(YOU MUST COMPLETE AND RETURN THIS AUTHORIZATION TO THE SO. CA DRUG BENEFIT FUND, P.O. BOX 27920, LOS ANGELES, CA 90027)

Signature: Date:

INCOMPLETE FORMS WILL BE RETURNED TO YOU

OFFICE USE ONLY

____________	____/_____/______	____/_____/___	____/______/____	_________	______
Entered by	Date	Eff Date	Sent to Employer	Deduct Amnt	Self Pay