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

# ENROLLMENT FORM

## GOLD AND PLATINUM PARTICIPANTS

**Return this form only if you want to enroll, change plans, add/delete dependents, or reject coverage**

☐ New Hire/Initial Enrollment ☐ Change of Address ☐ Add or ☐ Disenroll Dependents ☐ Change Plan(s) ☐ Transfer
(If married, New Hires must submit proof of marriage)

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

| Last Name | First Name / Initial | Middle | Gender 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 and stop payroll deduction 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. If I am a New Hire or if this is my first opportunity to enroll, and I am married, attached is proof of my marriage.

## 3. EMPLOYEE CONTRIBUTION AMOUNT & ENROLLMENT - CHECK ONE BELOW AND LIST YOURSELF AND EACH DEPENDENT YOU WISH TO ENROLL FOR COVERAGE. THIS FORM WILL REPLACE ANY PREVIOUS FORM YOU MAY HAVE SUBMITTED.

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

**I elect coverage for myself and my 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 myself and my eligible Dependents, I must list them below and I must submit a copy of my Marriage Certificate (if enrolling spouse) and copies of Birth Certificates for newly enrolled Dependent Children.

| →Participant | SSN or TIN (required) | Gender (M/F) | Date of Birth | |
|---|---|---|---|---|
| Spouse / Domestic Partner | SSN or TIN (required) | Gender (M/F) | Date of Birth | ☐ Enroll ☐ Disenroll |
| Child | SSN or TIN (required) | Gender (M/F) | Date of Birth | ☐ Enroll ☐ Disenroll |
| Child | SSN or TIN (required) | Gender (M/F) | Date of Birth | ☐ Enroll ☐ Disenroll |
| Child | SSN or TIN (required) | Gender (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 THE OPEN ENROLLMENT PERIOD 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:**<br>* For New Hires, HMO Options are not available to you until the 4th annual Open Enrollment after your date of hire.<br>☐ **INDEMNITY MEDICAL PLAN** (Anthem Blue Cross Prudent Buyer)<br>☐ * **KAISER DEDUCTIBLE HMO**<br>☐ * **UNITEDHEALTHCARE (UHC) HMO** | **I ELECT THE FOLLOWING DENTAL PLAN:**<br>☐ **INDEMNITY DENTAL PLAN** (through Delta Dental of California)<br>☐ **UNITED CONCORDIA PRE-PAID DENTAL PLAN** |

REQUIRED TO COMPLETE SECTION 5

## 5. 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? | ☐ Yes ☐ No | Under Medicare? ☐ Part A ☐ 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? | ☐ Yes ☐ No | Under Medicare? ☐ Part A ☐ 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? | ☐ Yes ☐ No | Under Medicare? ☐ Part A ☐ Part B | Name of Other Insurance Company Plan/Employer | Name of Insured |

## 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 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 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 THE REQUIRED AMOUNT OF THE WEEKLY 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 benefits provided by the Southern California Drug Benefit Fund. Employee Contributions must be made two months in advance of the month of coverage. For example, the monthly Employee Contribution deducted (at the appropriate weekly rate) from your paycheck(s) in February 2024 and paid to the Fund in March 2024 is for April 2024 coverage. **Therefore, if you do not already have coverage from the Fund, you should submit payment for two months' worth of Employee Contributions with your completed enrollment form.**

2. **You must complete this Form and return it to the Drug Fund Office** to authorize your Employer to deduct your Employee Contribution from your paychecks. The amount of your monthly Employee Contribution depends on the coverage tier you enroll in, as shown below. Please note that payroll deductions of the monthly Employee Contributions will be taken each month until you reject and disenroll from Drug Fund 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 as selected on the reverse side and below, currently:

☐ **Employee Only** **$8.00 per week ($34.67 per month)**

☐ **Employer with Child(ren)** **$12.00 per week ($52.00 per month)**

☐ **Employee with Spouse/Domestic Partner, with or without Child(ren)** **$16.00 per week ($69.33 per month)**

and to pay these amounts directly to the 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 that is owed, and that it is my responsibility to make full payment to the Fund by the due date indicated on the bill or I will lose coverage.

In addition, in the event there is a change to the amount of the weekly Employee Contribution required to maintain the coverage I selected, this authorization will remain in effect, and my Employer is authorized to deduct the amount necessary to maintain my coverage. I understand that the Drug 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 Drug Fund's eligibility rules by working the required "Qualifying Hours" and I must pay a monthly Employee Contribution.

**IMPORTANT: YOUR SIGNATURE IS REQUIRED BELOW TO AUTHORIZE YOUR EMPLOYEE PREMIUM DEDUCTION.**

**PLEASE PRINT CLEARLY**

| Last Name | First Name | M.I. | Union Local |
|---|---|---|---|
| | | | |

| Social Security Number or TIN Number | Date of Birth | ☐ Male ☐ Female **Must check one** | Home/Cell 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 THE COST OF COVERAGE (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 Amount | Self Pay |
|---|---|---|---|---|---|
| | ___/___/___ | ___/___/___ | ___/___/___ | | |