United Food and Commercial Workers Union and Employers Midwest Health Benefits Fund
918861 90TH AVE, SUITE A, MOKENA, IL 60448
800-621-5133 * FAX 847-384-0197 * www.ufcwmidwest.org

Dependent Coverage Enrollment Form — To Register your Dependents with the Health Benefits Plan

You must register your eligible dependents with the Health Plan for them to be considered for all benefits. Not all dependents are eligible for coverage—please see the definition of eligible dependents on the reverse side of this form. If your dependent information changes because of a birth, adoption, marriage, divorce, etc, you should contact the Benefits Fund Office.

Please fully complete this enrollment form and return it to the Benefits Fund Office. Completion of this form is not an indication of eligibility for benefits. You must be eligible for dependent coverage in order for your dependents to be covered. Please see your Plan booklet or contact the Benefits Fund Office if you have questions about your or your dependents' eligibility for coverage.

Attach a copy of your marriage certificate if married and a copy of the birth or adoption certificate for each child

Please Print Legibly

YOUR FULL NAME (EMPLOYEE-MEMBER)	YOUR SOCIAL SECURITY NUMBER	YOUR MEDICARE ID # (HICN) CHECK ☑ IF NONE ☐

STREET ADDRESS	CITY	STATE	ZIP

DAYTIME AREA CODE/TELEPHONE NUMBER	☐ MALE ☐ FEMALE	DATE OF BIRTH	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOW/ER	EMPLOYED AT

NAME OF SPOUSE	☐ MALE ☐ FEMALE	DATE OF BIRTH	DATE OF MARRIAGE	SOCIAL SECURITY NUMBER	MEDICARE ID # (HICN) CHECK ☑ IF NONE ☐

NAME OF CHILD (include last name if different from employee-member)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE-MEMBER— If "Other," please specify exact relationship
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______
			☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other ______

Eligible Dependents

If you are eligible for Dependent Coverage, your eligible dependents include:

- your lawful spouse of the opposite sex or, effective September 1, 2014, your lawful spouse of the same sex; and
- your children who are under 26 years of age.

Your children include:

- your natural children;
- your legally-adopted children or those for whom adoption proceedings have been started and who have been placed in your home by a licensed placement agency for the purpose of adoption; and
- your step-children if the child's natural parent lives with you.

If a dependent was covered up to the date coverage would otherwise end because of reaching age 26, and if on that date the dependent:

- is incapable of self-support due to mental retardation or physical handicap which began before the child attained age 26,
- is dependent upon you for more than one-half of his or her financial support and maintenance, and
- resides with you permanently and regularly for more than one-half of each year or lives in a treatment center,

then that dependent will be covered for so long as the incapacity and dependency continue, but not beyond the date on which your coverage ends.

Legal documentation of your dependent's status, such as by an original registered marriage certificate, certified government-issued birth certificate or an adoption certificate naming you or your spouse as the child's parent, is required by the Benefits Fund Office.