United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
9801 West Higgins Road, Suite 500 ♦ Rosemont, IL 60018-4740 ♦ 847-384-7000 ♦ 800-621-5133
FAX 847-384-0197 ♦ ufcwmidwest.org

Plan B5: Open Enrollment Period 11/01 through 12/31/17— Election and Payroll Deduction Authorization Form for Health Benefits Coverage

This information is for your use in making a change to your election status for Health Benefits coverage. If you need a Plan B5 Summary Plan Description (booklet), contact the Benefits Fund Office.

To elect coverage or to change your coverage, please complete and return this form by December 31st. The Open Enrollment Period ends on December 31st; your new election will become effective on January 1, 2018. If you do not return this form, your current election status for Health Benefits coverage will remain in effect.

To be covered under Plan B5, you must elect coverage and agree to a weekly contribution of $5 made by payroll deduction. Coverage is for you only, not family members. You may elect either of the following:

> **No Coverage**. You may elect not to participate and you will not receive any health coverage. There is no weekly payroll deduction if no coverage is elected.
>
> **Single Coverage**. You may elect Single Coverage to receive health coverage for yourself only (no family members) and make a weekly payroll deduction of $5. Additionally, you must work the hours necessary to maintain Single Coverage.

The weekly payroll deduction of $5 will be made under an Internal Revenue Code Section 125 Cafeteria Plan that your employer has adopted. Under the Plan, no federal or state tax is withheld from or due on your contribution amount. A summary of the Cafeteria Plan is included in the Plan B5 booklet under Appendix D.

If you have not already completed the following form or if you wish to make a change, please obtain a copy and complete and return it as soon as you can. The form is available on the Health Forms & Publications page at ufcwmidwest.org:

> **Authorization for Release of Personal Health Information.** Use this form to authorize us to discuss medical claims with a member of your family or other close individual. This may be very important if you are hospitalized or are otherwise unable to handle filing claims and asking questions about benefit payments. We do not have to receive this form in order to process your benefits, but please consider using it to help solve problems before they start.

You may elect coverage or drop coverage during the Open Enrollment Period at the end of each year. If you have a mid-year "change in coverage event" (such as marriage, divorce, spouse obtaining coverage from another source), you may make a coverage change within 30 days of the event, or 60 days after a Medicaid or CHIP event. These provisions are fully explained in the "Election of Coverage and Eligibility Provisions" section of the Plan B5 booklet.

(continued on reverse)

Plan B5 Open Enrollment Period 11/01 through 12/31/17—
Election and Payroll Deduction Authorization Form *(continued)*

Complete and return this form by December 31st to either enroll for or to drop Health Benefits coverage effective January 1, 2018.

Employee Information (please print):

Full Name ______________________________ ID # ______________________________
either your UFCW ID # or your SS #

Medicare ID # (HICN), if applicable______________________________ Date of Birth______________________

Street Address ____

City, State, ZIP Code ______________________________ Home Phone #______________________

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Employed By: ____

Coverage Election—Select one of the following coverage levels:

I understand that if I elect not to enroll in the Health Benefits Plan at this time, I will not be able to enroll until the next Open Enrollment Period, unless a Special Enrollment is necessary, as detailed in the *Plan B5 Summary Plan Description*. I also understand that by electing coverage on this form, I authorize my employer to deduct the weekly self-payment of $5 from my paycheck. This payroll deduction will remain in effect until changed on an enrollment date as detailed in the *Plan B5 Summary Plan Description*.

❒ **No Coverage:** I elect to waive coverage under the Health Benefits Plan.

❒ **Single:** I elect Single Coverage under the Health Benefits Plan and by signing this form, authorize my employer to deduct **$5.00** per week from my paycheck to cover myself only (no family members).

Employee Authorization:

I understand this election will remain in effect until changed, as set forth in the *Plan B5 Summary Plan Description*. I hereby certify that the information supplied on this form, to the best of my knowledge and belief, is true, correct and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

Employee Signature ______________________________ Date ______________________