United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
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Plan D5: 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 D5 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 D5, you must elect coverage and agree to a weekly contribution made by payroll deduction. Eligible employees may elect any of the following levels of coverage:

No Coverage. You may elect not to participate and you will not receive any health coverage or related benefits. There is no weekly payroll deduction if no coverage is elected.

Single Coverage. You may elect Single Coverage to receive health coverage and related benefits 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. Note that Single Coverage includes the disability Income Protection Benefit if you qualify as a full-time employee.

Family Coverage. You may elect Family Coverage to receive health coverage and related benefits for yourself and your eligible family members and make a weekly payroll deduction of $15. Additionally, you must work the hours necessary to maintain Family Coverage. In addition to this Election Form, please also complete and return the "Dependent Coverage Enrollment Form" along with a copy of your marriage certificate if you are married and a copy of the birth certificate for each child. The "Dependent Coverage Enrollment Form" is available on the Health Forms page at ufcwmidwest.org.

Your working spouse must elect employer-sponsored health coverage at his or her job if it is available. The Health Plan limits benefits to 50% of covered expenses for your spouse if he or she does not elect and maintain employer-sponsored health coverage that is available.

The weekly payroll deduction ($5 or $15) 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 D5 booklet under Appendix D.

If you have not already completed the following two forms (or if you wish to make a change to either of them), please obtain a copy and complete and return them as soon as you can. These forms are available on the Health Forms & Publications page at ufcwmidwest.org:

Designation of Beneficiary for the Death Benefit. Complete this form to name a beneficiary for the $15,000 Life Insurance Benefit.

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, drop coverage, or change 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, birth of a child, divorce, spouse obtaining or losing 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 D5 booklet.

(continued on reverse)

Plan D5: 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 enroll or change your status for Health Benefits coverage effective 01/01/18.

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—You must select one of the following coverage levels:

I understand that if I elect not to enroll myself or a dependent in the Health Benefits Plan at this time, I will not be able to enroll myself or a dependent until the next Open Enrollment Period, unless a Special Enrollment is necessary, as detailed in the *Plan D5 Summary Plan Description*. I also understand that by electing coverage on this form, I authorize my employer to deduct the applicable weekly self-payment from my paycheck. This payroll deduction will remain in effect until changed on an enrollment date as detailed in the *Plan D5 Summary Plan Description*.

❒ **No Coverage:** I elect to waive coverage under the Health Benefits Plan for myself and all of my dependents.

❒ **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).

❒ **Family:** I elect Family Coverage under the Health Benefits Plan and by signing this form authorize my employer to deduct **$15.00** per week from my paycheck to cover myself, my legal spouse and/or my children. I understand the *Working Spouse Information* section below must be completed. I have completed and attached the "Dependent Coverage Enrollment Form" to provide information on my family members.

Employee Authorization:

I understand this election will remain in effect until changed, as set forth in the *Plan D5 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_____

Working Spouse Information:

Complete this section if you have elected Family Coverage and are married; your spouse must sign the *Spousal Authorization* below.

Is your spouse employed? ❒ Yes ❒ No If "Yes," please provide the following:

Employed By_____ Phone # _____

Address, City, State, ZIP Code _____

Is health coverage available to your spouse through his/her employer? ❒ Yes ❒ No

If "Yes," is your spouse currently enrolled in his/her employer's plan? ❒ Yes ❒ No

Spousal Authorization

I hereby authorize my employer, if any, to release information regarding my employer's health insurance plan (including the Summary Plan Description) and my eligibility for coverage under that plan to the UFCW Unions and Employers Midwest Health Benefits Fund. I understand this authorization will remain in effect as long as I am eligible for benefits under the UFCW Unions and Employers Midwest Health Benefits Plan. I understand that the purpose and scope of this authorization is to allow the UFCW Unions and Employers Midwest Health Benefits Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

Spouse Signature _____ Date_____