UFCW LOCAL 360 HEALTH FUND

48 STILES LANE, SUITE 204, PINE BROOK, NJ 07058
TEL: (973) 299-6700 FAX: (973) 299-1288

DEPENDENT ENROLLMENT FORM B – AGE 19 TO 26

MEMBER NAME: _____ID:_____ Company Name_____

Please provide Enrollee information below

DEPENDENT: _____DOB:_____SSN:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone: _____ Mobile: _____ Email: _____

Are you currently employed? Yes___ No___

Date of Employment _____/_____/_____

Is Medical Coverage offered by Employer? Yes___ No___

Did you Decline coverage? Yes___ No___

Are you ELIGIBLE under any other plan? Yes___ No___

If ELIGIBLE under another plan please complete: **- IF COVERED BY ANOTHER PLAN YOU MUST INCLUDE A COPY OF YOUR ID CARD -**

Policy Holder's Name _____ Hospital ____ Major Medical ____ Rx ____ Dental ____ Vision ____ COBRA ____ Other _____

Insurer's Name: _____Insurer's Phone: _____ Effective Date of Coverage: _____Policy ID: _____

Insurer's Address: _____

If NOT ELIGIBLE for other coverage, please indicate the reason(s):

☐ Unemployed ☐ Benefits not offered ☐ Self-employed ☐ Not Eligible until _____ ☐ Full-Time Student ☐ Permanently Disabled

Are you covered by Medicare/Medicaid?	Indicate Coverage	Reason for Medicare/Medicaid	Effective Date
Yes ____ No _____	☐ Part A ☐ Part B ☐ Part D	☐ Disability ☐ Renal Failure	____/____/_____

Spouse Name: _____Spouse DOB: _____ Is Spouse Employed Y/N? _____Is Spouse Insured Y/N? _____ Insurer Tel No: _____

I certify that all of the above information is true and complete. I understand that any misleading or incorrect statements render this enrollment void and may be cause for termination of my medical benefits or denial of claim payment by the UFCW Local 360 Health Fund. I hereby authorize any entities and references named herein to give information in responding to inquiries in connection with this enrollment. I release said entities from all liability for issuing information relative to the Health Fund.

Dependent Signature: _____ Date Signed: _____