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 A – UNDER AGE 19

MEMBER NAME: _____ID:_____ Company Name_____

Please provide Enrollee information below.

DEPENDENT NAME: _____DOB:_____SSN:_____

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

Phone: _____ Mobile: _____ Email: _____

Is Child covered by another parent and/or step parent? Yes___ No___ If Yes, complete below coverage detail(s)

- IF COVERED BY ANOTHER PLAN YOU MUST INCLUDE A COPY OF YOUR ID CARD -

Parent/Step-Parent Name: **Parent/Step-Parent Phone:** **Relationship:** **Policy ID No:**

Parent/Step-Parent Address: _____

Please indicate all benefits that apply

_____ Hospital ____ Major Medical ____ Rx ____ Dental ____ Vision ____ COBRA ____ Other, Explain _____

Parent/Step-Parent Name: **Parent/Step-Parent Phone:** **Relationship:** **Policy ID No:**

Parent/Step-Parent Address: _____

Please indicate all benefits that apply

_____ Hospital ____ Major Medical ____ Rx ____ Dental ____ Vision ____ COBRA ____ Other, Explain _____

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: _____