UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1995 AND EMPLOYERS HEALTH AND WELFARE FUND

1740 Phoenix Parkway Atlanta, Georgia 30349 ● Phone: (770) 997-9910 or (800) 241-2136

2021 KROGER ANCILLARY ONLY

BENEFIT ENROLLMENT FORM

You can enroll online at https://ufcwemprfund.org/funds/HW-NASH/, by phone by calling 1-800-241-2136 or by completing this form. Please complete ALL requested information and return this form to the above address. Failure to complete the entire form (front and back) will result in a delay in processing of benefits.

PART 1. EMPLOYEE INFORMATION
Please type or print. Use black or blue ink only.

EMPLOYEE'S NAME FIRST NAME / MIDDLE INIT. / LAST NAME			**SOCIAL SECURITY NUMBER**
MAILING ADDRESS NO. & STREET		CITY	STATE & ZIP CODE
IS THE ABOVE HOME ADDRESS ON FILE WITH YOUR EMPLOYER? ☐ Y ☐ N		**EMAIL ADDRESS**	
DATE OF BIRTH MM/DD/YY	**GENDER** ☐ M ☐ F	**HOME TELEPHONE** (INCLUDE AREA CODE)	**CELL PHONE** (INCLUDE AREA CODE)
MARITAL STATUS CHECK ONE	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	**DATE OF MARRIAGE** MM/DD/YY	**DATE OF DIVORCE** MM/DD/YY

ARE EMPLOYED SOMEWHERE ELSE BESIDES KROGER? ☐ Y ☐ N — IF YES, COMPLETE PART 2, BELOW. IF NO, PROCEED TO PART 3.

PART 2. OTHER EMPLOYER INFORMATION
Please type or print. Use black or blue ink only

EMPLOYER'S FULL NAME	**HIRE DATE** MM/DD/YY	DOES YOUR OTHER EMPLOYER OFFER HEALTH INSURANCE? ☐ YES ☐ NO
EMPLOYER'S FULL MAILING ADDRESS		**TELEPHONE NUMBER**

PART 3. CHOOSE YOUR COVERAGE TIER AND PAYROLL DEDUCTION AMOUNT

You are eligible to enroll in the Ancillary Plan, which includes employee-only Dental, Vision, Life, AD&D and Weekly Disability benefits.

By checking the box for your selected coverage option, you are authorizing this weekly payroll deduction in the amount shown. You will not be able to add, change or rescind your coverage and associated payroll deduction until the next open enrollment period, except as permitted by the Notice of Special Enrollment Rights.

PLEASE SELECT ONE OF THE FOLLOWING
Check ✓ appropriate box

☐ EMPLOYEE ANCILLARY ONLY COVERAGE	$5.00/week
☐ I ELECT TO WAIVE COVERAGE FOR ALL BENEFITS	NA

PART 4. SIGNATURE

By submitting this form, I hereby certify that the information provided, to the best of my knowledge and belief, is true, correct and complete. I understand that any false statements may affect my continued eligibility for benefits under the Fund. By providing the information contained in this form, I further understand and authorize the Fund, its representatives, and/or its third-party service providers to contact me by telephone, cell phone, e-mail, or mail, for purposes of Fund administration and healthcare related activities such as enrollment or medical management. I consent and agree that the Fund and/or its third-party service providers may, from time to time in their sole discretion, make calls or send text messages to me using prerecorded or artificial voice messages and/or through the use of an automatic telephone dialing system to any phone number provided in this form, including to my cell phone that could result in charges to me. I understand I may revoke my consent to receive such calls or messages sent to my cell phone at any time. I further understand that, if applicable, I am authorizing the weekly pre-tax payroll deductions for any required participant contributions detailed during this enrollment process. I have read and understand the terms and conditions of these payroll deductions and the Notice of Special Enrollment Rights.

Signature:______________________________ **Date:**____________________

TO COMPLETE YOUR ENROLLMENT YOU MUST EITHER:

- Enroll online by visiting the Fund's Enrollment website at https://ufcwemprfund.org/funds/HW-NASH/ **OR**
- Enroll via phone by calling the Fund Office at 1-800-241-2136 **OR**
- Enroll via paper by completing and returning this form to:

United Food and Commercial Workers Union Local 1995 and Employers Health and Welfare Fund
1740 Phoenix Parkway Atlanta, Georgia 30349
or via FAX at 770-909-6596

UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 1995 AND
EMPLOYERS HEALTH AND WELFARE FUND
1740 Phoenix Parkway, Atlanta, Georgia 30349
Phone: 770.997.9910 or 800.241.7701 Fax: 770.909.6596

Beneficiary Designation Form Instructions

You may name any person, persons, institution, trust, estate, religious or charitable institution or other entity as your primary or contingent beneficiary(ies). List a person's full name (use proper name, not nickname), address, social security number and relationship to you. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related". If a religious or charitable institution is listed, include the institution's tax identification number.

If you name more than one beneficiary, it is understood that the beneficiaries listed and living at the time of your death will share equally in the distribution of the death benefit.

If you wish to indicate unequal distribution among beneficiaries, you may do so by stating the percent of the insurance benefit to be paid to each. The listed percentages must add up to 100%.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1		
Primary Name: Jane Doe	Relationship: Spouse	Benefit Percentage: 100%
Contingent Name: Donny Doe	Relationship: Nephew	Benefit Percentage: 100%
Example #2		
Primary Name: Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Primary Name: Jane Doe	Relationship: Daughter	Benefit Percentage: 25%
Primary Name: Jane Doe	Relationship: Son	Benefit Percentage: 25%
Contingent Name: Donny Doe	Relationship: Nephew	Benefit Percentage: 100%
If additional space is required, write “See attached, on the beneficiary line on this form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**		

If you need assistance in completing this form, please contact the Fund Office.

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Beneficiary Designation Form

☐ Initial Beneficiary Designation OR ☐ Change of all prior beneficiary designation(s) (check only one box)

I hereby-revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and· direct that the insurance proceeds payable under the policy be paid as indicated below. The beneficiary designation is effective when received by the Fund Office.

Employee Name:	**Employee ID Number:**	**Social Security Number:**
Employee Address:	**Telephone Number:**	
Employer:	**Policy Number:**	

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, please contact the Fund Office.

PRIMARY BENEFICIARY(IES)		
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:

CONTINGENT BENEFICIARY(IES)		
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies). Please note that in no event can a beneficiary be changed by a Power of Attorney (POA).

Signature of Employee: ______________________________________ Date: _________________________

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).