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 FULL-TIME PLAN G

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

The amount that you will pay towards your coverage through payroll deduction will depend on the tier of coverage that you select. By checking the box for your selected tier, 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.

SPECIAL NOTE ON SPOUSE COVERAGE: If your spouse is eligible to enroll in a group health plan offered by his/her non-Kroger employer and does not enroll in that coverage, this Fund will not provide any benefits for your spouse. If your spouse is enrolled in his/her other group coverage, the spouse can be enrolled in this Fund for secondary Full Coverage by paying an extra $45 per week. If your spouse does not have access to any other non-Kroger group health plan coverage, you can enroll your spouse under Full Coverage or Spouse Ancillary Coverage (consisting only of dental and vision benefits).

SPECIAL NOTE ON COORDINATION OF BENEFITS (COB): Prior to choosing to enroll your dependent(s) for benefits, you should review how this Fund will coordinate payment with any other health insurance that your dependent(s) may have. This Fund utilizes **Non-Duplication Coordination of Benefits** for medical coverage. This means that when this Fund pays on a secondary basis, it will only pay the difference in what the Fund would have paid if it had been primary and what the other coverage actually paid as primary. For example, if you have a $100 medical claim and this Fund would have paid $80 if it was primary and the other coverage actually paid $80, then the difference is $0 and this Fund will not pay any additional amounts. This Fund provides no secondary coverage for prescription drugs.
Dual Employees and COB – If you are covered as both an employee and a dependent under this Fund, the Non-Duplication COB methodology **will not** apply to you and your medical claims will be coordinated up to 100% of the total allowed charge for medical and prescription drugs.

PLEASE SELECT ONE OF THE FOLLOWING
Check ✓ appropriate box

If required and you did not complete a health (biometric) screening by November 30, 2020, you will be charged a weekly risk premium. The risk premium does not apply to employees enrolling in Ancillary Only coverage.

Did you complete your health screening? ☐ Y ☐ N

Full Coverage consists of medical, prescription, dental, vision, life insurance, AD&D and weekly disability benefits.
Employee Ancillary Only Coverage consists of dental, vision, life insurance, AD&D and weekly disability benefits.
Spouse Ancillary Only Coverage consists of dental and vision coverage only.

IF YOU ARE ENROLLING FOR FULL COVERAGE

	WITH SCREENING	WITHOUT SCREENING
☐ EMPLOYEE ONLY	$13.00/week	$16.90/week
☐ EMPLOYEE & SPOUSE	$25.00/week	$32.50/week
☐ EMPLOYEE & CHILD(REN)	$22.50/week	$29.25/week
☐ EMPLOYEE & FAMILY	$35.00/week	$45.50/week
☐ EMPLOYEE ONLY + SPOUSE ANCILLARY	$16.00/week	$19.90/week
☐ EMPLOYEE & CHILD(REN) + SPOUSE ANCILLARY	$25.50/week	$32.25/week

If coverage will be secondary, a $45 per week surcharge will be applied.

IF YOU ARE ENROLLING FOR ANCILLARY ONLY COVERAGE

☐ EMPLOYEE ONLY	$3/week
☐ EMPLOYEE & SPOUSE	$6/week

IF YOU ARE NOT ENROLLING FOR ANY BENEFITS

☐ I ELECT TO WAIVE COVERAGE FOR ALL BENEFITS

NOTE: If both you and your spouse are eligible under this Plan, you must both enroll separately. If you both enroll and elect to cover each other, your employee copremiums will be adjusted on an individual basis. Contact the Fund Office for assistance with your elections.

PART 4. DEPENDENT CHILD INFORMATION Please type or print. Use black or blue ink only.

Complete only if you elected Employee & Child(ren) coverage in PART 3. The Fund provides coverage for eligible dependent children up to age 26.

SSN (Social Security) or ITIN (Individual Tax) numbers are required for the enrollment process. Please enter each dependent's SSN/ITIN. If you have applied for a SSN (newborn, etc.) and not yet received it, please enter 100-10-1000, and notify the Fund Office immediately once you have received the Social Security Number. Please note the "staged" SSN (100-10-1000) may only be used for one dependent. If you are missing more than one SSN/ITIN contact the Fund Office.

NAME FIRST LAST	SOCIAL SECURITY NUMBER	DATE OF BIRTH	M/F	IS CHILD TOTALLY DISABLED?	DOES CHILD RESIDE WITH YOU?	HAS OTHER MEDICAL COVERAGE?	HAS OTHER DENTAL COVERAGE?	RELATIONSHIP TO INSURED*
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
				☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	

* Indicate Natural child, stepchild, adopted, foster child, or legal custody. Please note that the Fund Office may request copies of birth certificates, adoption papers, custody awards or other proof of relationship in order to complete enrollment.

PART 5. DEPENDENT SPOUSE INFORMATION Please type or print. Use black or blue ink only.

Complete only if you elected Full Spouse Coverage or Spouse Ancillary Coverage in PART 3.

SPOUSE'S NAME FIRST NAME MIDDLE INIT. LAST NAME	SOCIAL SECURITY NUMBER	DATE MARRIED MM/DD/YY	DATE OF BIRTH MM/DD/YY

IS THIS SPOUSE CURRENTLY EMPLOYED? ☐ Y ☐ N **IF YES, PROVIDE NAME AND ADDRESS OF SPOUSE'S EMPLOYER:**

DOES THIS SPOUSE HAVE OTHER COVERAGE? Medical ☐ Y ☐ N; Dental ☐ Y ☐ N; Vision ☐ Y ☐ N

NOTE: *IF YOU HAVE ELECTED FULL SPOUSE COVERAGE,* ***YOU MUST COMPLETE THE FULL SPOUSE COVERAGE FORM INCLUDED WITH THIS PACKET.*** *YOU AND YOUR SPOUSE MUST COMPLETE AND RETURN THE FULL SPOUSE COVERAGE FORM ALONG WITH ALL REQUIRED DOCUMENTATION BY THE STATED DEADLINE IN ORDER FOR YOUR SPOUSE TO RECEIVE FULL SPOUSE COVERAGE.*

IF YOU HAVE INDICATED THAT A DEPENDENT HAS OTHER COVERAGE, YOU MAY RECEIVE AN ADDITIONAL FORM TO COMPLETE TO PROVIDE DETAILS ABOUT THAT COVERAGE. PLEASE COMPLETE AND RETURN TIMELY TO AVOID ANY DELAY IN PROCESSING OF CLAIMS.

PART 6. MEDICARE ELIGIBILITY INFORMATION Please type or print. Use black or blue ink only.

IF YOU OR A DEPENDENT ARE COVERED BY OR ELIGIBLE TO ENROLL IN MEDICARE, COMPLETE THE FOLLOWING

COVERED INDIVIDUAL'S NAME	MEDICARE ID # (HICN)	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	PART D EFFECTIVE DATE	IF ELIGIBLE DUE TO ESRD, PROVIDE ONSET DATE

PART 7. 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) 241-2136

Full Spouse Coverage Form
Online and Telephone Enrollment

OUR RECORDS INDICATE THAT YOU ELECTED TO ENROLL YOUR SPOUSE IN FULL SPOUSE COVERAGE DURING YOUR ONLINE OR TELEPHONIC ENROLLMENT. PLEASE NOTE THAT YOUR SPOUSE WILL NOT BE ENROLLED UNTIL THIS FORM IS COMPLETED AND RETURNED. **FAILURE TO SEND US THE PROPER VERIFICATION WILL RESULT IN YOUR SPOUSE NOT BEING ENROLLED IN FULL SPOUSAL COVERAGE BY THE FUND FOR 2021.**

THIS FORM CAN BE RETURNED TO THE ADDRESS ABOVE OR BY FAX AT 770-909-6596.

NAME:_____ **SOCIAL SECURITY #:** _____

PART 1 – *Check ✓ one of the following options:*

- ☐ I am currently enrolled in Full Spouse Coverage under the Fund. My spouse either remains unemployed or my spouse remains employed with the same employer and still does not qualify for health coverage with that employer.
- ☐ I am currently enrolled in Full Spouse Coverage under the Fund, BUT my spouse is now eligible to enroll (or will become eligible in 2021) for health coverage through his or her employer **OR** my spouse has changed his or her employer. ***Your Spouse must complete Part 2 of the Full Spouse Coverage Form.***
- ☐ I want to add my spouse for the first time. ***Your spouse must complete Part 2 and attach the documents listed in Part 3.***

PART 2 – *TO BE COMPLETED BY YOUR SPOUSE*

I am (check ✓ one of the following)**:**

- ☐ NOT employed
- ☐ Employed WITHOUT access to medical benefits from my employer
- ☐ Employed WITH access to but not enrolled in medical coverage from my employer
- ☐ Employed WITH access to and ENROLLED in medical coverage from my employer

SPOUSE'S EMPLOYER NAME AND ADDRESS	**SPOUSE'S EMPLOYER TELEPHONE NUMBER**

SPOUSE'S CERTIFICATION

I hereby certify that the information provided is correct. I understand that any false statements may affect my continued eligibility for benefits under the Fund. I authorize the Fund to contact my employer, if applicable, for information related to healthcare coverage information offered by my employer and authorize its use in the application for coverage under UFCW Unions & Employers Health & Welfare Fund - Nashville.

Spouse Signature:_____ Date:_____

Certification by Notary:
Subscribed and sworn before me on this_____ day of_____, 20__.

_____
Notary Public

My commission expires: _____

PART 3 – *Additional Documents (Only Required if you are enrolling your spouse in Full Spouse Coverage for the first time)*

If you want to add your spouse to your Fund coverage for the first time, please complete Part II of the Full Spouse Coverage Form and provide the following:

1. A copy of your marriage license or certificate.
2. If you have been married for more than three years, we also need one form of dated (within 6 months) documentation establishing current marital status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, or front page of your jointly-filed 2019 tax return (with blacked out financial information).

THIS FORM CAN BE RETURNED TO THE ADDRESS ABOVE OR BY FAX AT 770-909-6596.

MUST BE COMPLETED BY SPOUSE'S EMPLOYER IF YOUR SELECTION ABOVE INDICATES "EMPLOYED WITH ACCESS TO MEDICAL COVERAGE"

Name of Employee: _____

Employee's Date of Hire: _____

Does your Company offer an Affordable Care Act (ACA) compliant health plan? Yes ☐ No ☐

If yes: IS THE PERSON NAMED ABOVE AS Spouse eligible for such health plan? Yes ☐ No ☐

(Please note that "eligible" means that coverage has been offered and does not require that the Spouse has elected to enroll in such coverage.)

Is this person named above as Spouse enrolled in such medical coverage? Yes ☐ No ☐

If your company does offer an ACA complaint health plan, but the Spouse is not eligible for such coverage, please provide a brief description of why he/she is not eligible (i.e., waiting period, works in ineligible job position or status).

If the reason is due to a waiting period, please provide date it will be available: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Authorized Employee Signature: _____ Date: _____

Printed Name: _____ Title: _____

Form Updated 11/17/2020

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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Phone: 770.997.9910 or 800.241.7701 Fax: 770.909.6596

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).