

Dependent Coverage Registration Form – To Register your Dependents with the Health Benefits Plan

You must register your eligible dependents with the Health Plan for them to be considered for all benefits. Not all dependents are eligible for coverage—please see the definition of eligible dependents on the reverse side of this form. If your dependent information changes because of a birth, adoption, marriage, divorce, etc, you should contact the Benefits Fund Office.

Please fully complete this registration form and return it to the Benefits Fund Office. Completion of this form is not an indication of eligibility for benefits. You must be eligible for dependent coverage in order for your dependents to be covered. Please see your Plan booklet or contact the Benefits Fund Office if you have questions about your or your dependents' eligibility for coverage.

Please Print Legibly

YOUR FULL NAME (EMPLOYEE-MEMBER)		YOUR SOCIAL SECURITY NUMBER or UFCW ID #		YOUR MEDICARE ID # (HICN)	CHECK <input checked="" type="checkbox"/> IF NONE <input type="checkbox"/>
STREET ADDRESS		CITY	STATE	ZIP	
DAYTIME AREA CODE/TELEPHONE NUMBER ()	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW/ER	EMPLOYED AT

NAME OF SPOUSE	DATE OF BIRTH	DATE OF MARRIAGE	SOCIAL SECURITY NUMBER	MEDICARE ID # (HICN)	CHECK <input checked="" type="checkbox"/> IF NONE <input type="checkbox"/>
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NAME OF CHILD (include last name if different from employee-member)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE-MEMBER— If "Other," please specify exact relationship	MEDICARE ID # (HICN) or, if none, SOCIAL SECURITY NUMBER
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	
		<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	

Eligible Dependents

If you are eligible for Dependent Coverage, your eligible dependents include:

- your lawful spouse of the opposite sex; and
- your children who are under 26 years of age

Your children include:

- your natural children;
- your legally-adopted children or those for whom adoption proceedings have been started and who have been placed in your home by a licensed placement agency for the purpose of adoption; and
- your step-children if the child's natural parent lives with you.

If a dependent was covered up to the date coverage would otherwise end because of reaching age 26, and if on that date the dependent:

- is incapable of self-support due to mental retardation or physical handicap which began before the child attained age 26,
- is dependent upon you for more than one-half of his or her financial support and maintenance, and
- resides with you permanently and regularly for more than one-half of each year or lives in a treatment center,

then that dependent will be covered for so long as the incapacity and dependency continue, but not beyond the date on which your coverage ends.

Legal documentation of your dependent's status, such as by an original registered marriage certificate, certified government-issued birth certificate or divorce decree, may be required by the Benefits Fund Office.