Alaska United Food and Commercial Workers Trust Funds

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Phone (206) 441-7574 ● Toll-Free (800) 478-8329 ● Fax (206) 505-WPAS (9727) ● Website www.akufcwtrust.com

Administered by
Welfare & Pension Administration Service, Inc.

November 14, 2017

TO: ALL ACTIVE PARTICIPANTS
ALASKA UFCW HEALTH AND WELFARE TRUST

RE: ANNUAL OPEN ENROLLMENT

THIS NOTICE CONTAINS IMPORTANT INFORMATION REGARDING ANNUAL OPEN ENROLLMENT FOR YOUR HEALTH COVERAGE AND BENEFIT CHANGES EFFECTIVE JANUARY 1, 2018

PLEASE READ THIS INFORMATION CAREFULLY

DEADLINE TO ENROLL FOR HEALTH COVERAGE IS DECEMBER 20, 2017

FAILURE TO COMPLETE AND RETURN THE ENCLOSED ENROLLMENT FORM WILL CAUSE LOSS OF HEALTH PLAN ELIGIBILITY

The Alaska United Food and Commercial Workers Health and Welfare Trust's (the Trust) annual open enrollment is being held through December 20, 2017. **All employees must affirmatively elect whether they wish to enroll themselves and each eligible dependent into the health plan.**

Payroll Deductions

The Trust requires a weekly payroll deduction of $15.00 per week to cover yourself, $30.00 per week to cover yourself and all eligible children, or $35.00 per week to cover yourself and your family, including your spouse.

Dependent Coverage

During the open enrollment period, you have the opportunity to add or remove your eligible dependents from your health plan. Any change you make now will be effective **January 1, 2018.** Note: Members in their first 12 months of coverage through the Trust are generally not eligible to cover dependent children, and are not generally eligible to cover their spouse during the first 24 months of coverage, unless the member has completed 1,200 hours of covered employment. A spouse that has health coverage available through his or her employer but does not elect or accept such coverage is disqualified from coverage under this Plan.

If you do not list your dependents on the Enrollment Form at this time, and if you do not authorize the appropriate weekly payroll deduction, you will not be able to enroll your dependents until the next annual open enrollment period, unless your dependents lose other group coverage due to certain circumstances, such as termination of employment, reduction of hours, exhaustion of COBRA continuation coverage, etc.

Open Enrollment Deadline
Your completed Enrollment Form must be returned to the Administration Office **no later than December 20, 2017.** This will ensure that the Trust records and eligibility reflect your election. Keep the yellow copy for your records. ***Please be advised that failure to complete and return this form will cause loss of health plan eligibility for you and your dependents.*** You may return your completed Enrollment Form in one of the following ways:

- Use the enclosed return envelope
- Scan and e-mail to forms@wpas-inc.com
- Fax to (206) 505-9727

If you have questions regarding the open enrollment process, please contact the Member Services Department of the Administration Office at (800) 478-8329, option 4.

Summary of Benefits and Coverage
In accordance with the Affordable Care Act as amended, the Trust is required to provide a **Summary of Benefits and Coverage** (SBC) to all participants and beneficiaries; you will find this document enclosed. Please note: The SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.

The SBC is intended to help you better understand the coverage currently available to you and what the Plan covers and what it costs. Included in the SBC are "coverage examples," which estimate what the Plan might cover in common medical situations. It is important to note that the SBC is only a **summary** and does not replace the Summary Plan Description (Plan booklet). **The SBC is not intended to be a cost estimator and should not be used to estimate your actual costs.**

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment." To obtain a copy of the Uniform Glossary of Terms, contact the Administration Office at (800) 478-8329.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. Should you have any questions, please contact the Administration Office at (800) 478-8329.

Sincerely,

Administration Office
Alaska UFCW Health and Welfare Trust

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Enclosures

Alaska UFCW Health and Welfare Trust
Annual Open Enrollment

Instructions for Completing Annual Enrollment Form:

1. Check the appropriate box(es) in the "Purpose for Completing Form" box.

   A. If you are an employee electing coverage, check the "Annual Enrollment" box.

   B. If you wish to add dependent child(ren) and/or spouse, check the "Addition of Dependents" box.

   C. If you have a new address, name change, or wish to make other changes, check the appropriate boxes.

2. Check the appropriate box for the weekly payroll deduction you authorize: Employee Only; Employee + Child(ren); or Employee + Spouse and/or Family. Or if you are declining coverage, check the I Decline Coverage Until Next Open Enrollment box.

   Note: Members are typically not eligible to cover their spouse in their first twenty-four (24) months of eligibility, unless the member has completed 1200 hours of employment. Contact the Administration Office for more information.

   A spouse that has health coverage available through his or her employer but does not elect or accept such coverage is disqualified from coverage under this Plan.

   If your spouse is not enrolled and you do not complete the Enrollment Form to add him or her to your coverage at this time, you will not be able to do so until the next annual Open Enrollment, unless your spouse loses other group coverage due to certain circumstances, such as termination of employment, reduction of hours, exhaustion of COBRA continuation coverage, etc.

3. Complete the next section with your name and social security number. Write in the names of all dependents that will be covered by the Plan (i.e., yourself, your spouse, your children, etc.). Be sure to indicate your current address and telephone number.

4. Complete the next section to show if you have any *other* group medical coverage for yourself, your spouse, and/or children.

5. Designate a beneficiary to receive the proceeds of your Health and Welfare and Pension Death Benefits.

6. Sign and date the Enrollment Form. Keep the **yellow copy** for your records. Return the **white copy** to the Administration Office in the envelope provided by **December 20, 2017.** You may also fax your completed Enrollment Form to (206) 505-9727, or scan and e-mail to forms@wpas-inc.com.

Important Note: **Failure to complete and return this form will cause loss of health plan eligibility for you and your dependents. If all required information is not provided, the Enrollment Form will be returned to you for completion.**

Administration Office
Alaska UFCW Health and Welfare Trust

ALASKA U.F.C.W. HEALTH AND WELFARE AND PENSION TRUSTS

ENROLLMENT-DECLINATION OF COVERAGE-BENEFICIARY-DEPENDENT COVERAGE AUTHORIZATION FORM

F45

ANSWER ALL QUESTIONS & RETURN IMMEDIATELY

PURPOSE FOR COMPLETING FORM ☐ Annual Enrollment ☐ New Employee ☐ Beneficiary Change
☐ Addition of Dependents ☐ Address Change ☐ Name Change ______________ (Previous Name) ☐ Other ________

PAYROLL DEDUCTION AUTHORIZATION: I authorize a weekly payroll deduction by my employer for health coverage for myself and/or my eligible dependents. Check one of the following boxes to confirm who you will cover: ☐ Employee Only; ☐ Employee + Child(ren); ☐ Employee + Spouse and/or Family ☐ I Decline Coverage Until Next Open Enrollment

***A SPOUSE WHO IS ELIGIBLE FOR COVERAGE THROUGH HIS OR HER OWN EMPLOYER IS DISQUALIFIED FROM COVERAGE UNDER THIS PLAN IF HE OR SHE HAS NOT ELECTED/ACCEPTED SUCH COVERAGE.**

Important Note: If you do not enroll your eligible dependents for coverage at this time, you will not be able to do so until the next annual Open Enrollment. Failure to complete and return this form will cause loss of health plan eligibility.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Month/Day/Year)	RELATIONSHIP TO MEMBER
Member/Employee				Self
Mailing Address (Street, City, State, Zip Code)				
Phone Number		E-mail Address		
Spouse* You must check the box above for weekly payroll deduction				Date of Marriage:
Dependent Children* You must check the box above for weekly payroll deduction				

OTHER INSURANCE INFORMATION – **YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by or eligible to enroll in any other group medical insurance plan including Medicare? YES ☐ NO ☐ ***If "YES," please provide the information requested below. If "NO," please go to #3 below.***

Name of Subscriber with Other Coverage ______ **Subscriber Social Security Number** ______

Name and Address of Other Insurance Company ______ **City** ______ **State** ______ **Zip** ______

Policy or ID Number: If Medicare, copy of Medicare ID must be on file with the Administration Office.

2. Other insurance covers: Employee ☐ Spouse ☐ Children ☐ Date Coverage Began: ____________
3. Is your spouse employed? YES ☐ NO ☐ If yes, list employer: ____________
4. Does spouse's employer provide access to group health insurance? YES ☐ NO ☐
5. If yes, was that coverage declined? YES ☐ NO ☐ Or accepted? YES ☐ NO ☐

HEALTH & WELFARE/PENSION BENEFICIARY DESIGNATION

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Pension Plan Document or Health and Welfare Plan Document.

Beneficiary Name ____________ (Last) ____________ (First) ____________ (**Social Security Number**)

Beneficiary Address ____________

Unless otherwise noted, if two or more beneficiaries are named, proceeds shall be paid in equal shares to the above beneficiaries.

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supercedes any beneficiary designation signed prior to the date shown below. I am an eligible participant as a member of the bargaining unit, retiree, or covered by special agreement. I hereby expressly acknowledge that false information given to an employee benefit plan is a crime and a violation of AS 21.36.360.

Date: ____________ ____________

Participant Signature ***(must be signed by participating employee)***

RETURN WHITE COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203

Scan and email to: forms@wpas-inc.com or Fax to: (206) 505-9727

RETAIN YELLOW COPY FOR YOUR RECORDS