UFCW Local 1625 and Employers Health and Welfare Fund

c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
1 (800) 842-5899 | Fax (954) 266-2079

Enrollment Form

(If you prefer to complete this paper form, you may return it by mail or fax as listed above, or securely upload at https://www.nebainc.com/1625upload.)

1. First, tell us about yourself.

Please complete all boxes.

First Name		Middle Initial		Last Name	
Gender	Male Female	Birthdate	/ /	SSN	
Address					
City, State Zip		Marital Status			
Employer Name					

2. If we need to get in touch with you, what do you prefer?

Please mark your preferred method.

☐	Call me	Home: ( ) -	Cell: ( ) -	Work: ( ) -
☐	Email me	Email Address:		Mail to me at the address listed above

3. Do you want to enroll for coverage under the Plan?

Please choose one of the options below.

☐	YES, enroll me for employee only coverage.	I request coverage under the UFCW Local 1625 and Employers Health and Welfare Fund (the Plan). If I am enrolling dependent children, I understand that I will be required to submit supporting documents which demonstrate that my dependents meet the Plan's definition of eligible dependent, such as my children's birth certificates. Signature: Date:
☐	YES, enroll me & my eligible dependents.	
☐	NO, do not enroll me. I have other health plan coverage.	I understand that by declining coverage, I am waiving all benefits to which I am entitled. Under the Affordable Care Act, if I do not have health insurance, I may be subject to a fee called the individual shared responsibility payment. Signature: Date:
☐	NO, do not enroll me. I do not have other health plan coverage.	

4. Which doctor in the CIGNA OAP Network will provide your primary care?

If you don't currently have an in network Primary Care Physician (PCP), please call Cigna CareAllies at 1-800-768-4695. Cigna CareAllies can help you find a doctor in your area that participates in the Cigna OAP Provider Network. You are not required to name a PCP, but you are encouraged to do so. It's important to establish a relationship with a PCP before you get sick! If you don't, it can be difficult to get an appointment when you need one.

Physician Name:	**Physician Address:**
Physician Phone Number:	

5. Are you enrolling dependents? If so, please complete the section below.

To enroll your dependents you will need to provide copies of their social security cards (if available), birth certificates (required for children), and a marriage certificate (required for stepchildren). Other documents may be required and could be requested by NEBA. To add dependents, please fill out their information below and submit the required documents to NEBA via fax, secure email, website upload, or mail within 15 days. Dependents will not be enrolled in the Plan if the documentation is not submitted timely.

The term "Dependent" is defined in the Plan Document as a Covered Employee's natural child, adopted child, stepchild, foster child, and/or any child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by the Covered Employee.

Complete the following section if you are enrolling dependent children.			
Dependent 1:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 2:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 3:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 4:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	
Dependent 5:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**	**Phone:**	

Please contact NEBA if you wish to add more than five dependent children.

That's it! *Thank you for completing your enrollment form.*