United Food and Commercial Workers Union Local 1189 & St. Paul Food Employers Health Fund

3001 Metro Drive – Suite 500 | Bloomington, MN 55425 | 952.854.0795 | 800.535.6373

FAMILY UPDATE FORM

Directions: Complete this Family Update Form and return it to the Fund Office. **You must submit the following items to the Fund Office with this Family Update Form, if you have not previously provided them to the Fund Office (as applicable):**

- If you or your Dependent(s) have other group medical coverage, you must include a photocopy of the front and back of the I.D. card for the other coverage.
- If you are married, you must include a copy of your Marriage Certificate.
- If you are enrolling a Dependent child(s), you must include a copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable). If there is a divorce decree that addresses medical coverage for any Dependent Child, please supply a copy of the decree.

Insured's Data

Name:	Social Security Number:
Date of Birth	Phone Number:
Address:	Marital Status: ☐ Single ☐ Married ☐ Divorced Date of Marriage or Divorce:_____

Spouse's Data

Name:	Social Security Number:
Date of Birth	Phone Number:
Spouse's Employer Name:	Employer's Address:
Employer's Phone Number:	

Spouse's Insurance Data

Does your spouse have other Group Medical Coverage? ☐Yes ☐No	If yes, is the coverage type: ☐Single or ☐Family
Medical Insurance Carrier Name:	Insurance Carrier Phone Number:
Insurance Carrier Address:	Group Contract Number: Effective Date:_____ Term Date:_____
Does coverage include Dental? ☐Yes ☐No	Does coverage include Vision? ☐Yes ☐No

Please provide the complete names and birth dates, etc., for all covered dependents. If a dependent child is employed and/or has other insurance, please include that information. In addition, if you are married, please attach a copy of your marriage certificate. If there is a divorce decree that addresses medical coverage for any dependent children, please supply a copy of that decree.

Dependent's Name	Relationship	DOB	Soc. Sec. No.	Sex	Employer/Other Insurance

If any of the information changes during the calendar year, you must advise us immediately

OVER ➩

Medicare Information including Medicare Part D - Prescription Drug Program

Your Name:____ Date of Birth _____ /_____ /_____ Medicare HIC #: _______

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

Spouse's Name:____ Date of Birth _____ /_____ /_____ Medicare HIC #: _______

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

If you are retired, please indicate retirement date: You: _____ /_____ /_____

Do you have Medicare due to:
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Does your spouse have Medicare due to
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Life-Changing Events

If you get married, provide the Fund Office with:
- A copy of your marriage certificate
- Your spouse's date of birth
- A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
- The birth date, birth certificate, effective date of adoption papers, court order, or marriage certification (for stepchildren)
- A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:
- A copy of your separation or divorce decree
- A copy of any QDRO
- If you have children for whom you do not have custody, a copy of any QMCSO

If your spouse wants to continue coverage, he or she must:
- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage

We are pleased to be of service to you. Please contact this office if you have any questions.

Please sign below, verifying that the above statements are true to the best of your knowledge and belief. Your Signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

____ _____________________________

Participant's Signature *Date of Signature*