United Food & Commercial Workers Local 1000
Kroger Dallas Health & Welfare Plan "Med-1000"
ADMINISTERED BY:
National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100
Pembroke Pines, FL 33028
1-800-567-5899

ENROLLMENT INFORMATION
PREMIUM PLAN – DEPENDENT COVERAGE

EMPLOYEE INFORMATION

First Name		**Middle Initial**		**Last Name**	
Gender	☐ Male ☐ Female	**Birthdate**	/ /	**SSN**	
Address					
City, State Zip				**Marital Status**	
Preferred Contact Method:	☐ Phone ☐ Email ☐ U.S. Mail			**Phone/Email:**	
Employer/Store #				**Date of Hire**	

COVERAGE OPTION ELECTED

	Coverage Tier	Weekly Contribution Rate
☐	Employee Only	$12.00
☐	Employee and Child(ren)	$15.00
☐	Employee and Spouse	$22.50
☐	Employee and Family	$30.00
☐	Waive Coverage	N/A

SPOUSE INFORMATION

First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SSN	
Address					
City, State, Zip					
Employer Name					
Employer Address				Phone Number	
My spouse has other coverage available?	☐ Yes ☐ No				

DEPENDENT CHILD INFORMATION

DEPENDENT 1					
First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SSN	
Address					
City, State, Zip					
My dependent has other coverage available?	☐ Yes ☐ No				

DEPENDENT 2					
First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SSN	
Address					
City, State, Zip					
My dependent has other coverage available?	☐ Yes ☐ No				

DEPENDENT 3						
First Name		Middle Initial		Last Name		
Gender	☐ Male ☐ Female	Birthdate	/ /		SSN	
Address						
City, State, Zip						
My dependent has other coverage available?		☐ Yes ☐ No				

I ELECT CO-PAYMENTS FOR THE BENEFITS AND AUTHORIZE WEEKLY PAYROLL DEDUCTIONS IN THE AMOUNT OUTLINED ABOVE BASED UPON THE COVERAGE TIER ELECTED.
IF I DO NOT ELECT A CO-PAYMENT FOR COVERAGE OR DO NOT RETURN THIS APPLICATION TIMELY, I UNDERSTAND I WILL BE WAIVING ALL BENEFITS OFFERED BY THE MED-1000 PLAN INCLUDING LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF TIME, VISION, DENTAL AND MEDICAL, AS WELL AS THE COMPANY SPONSORED PRESCRIPTION DRUG BENEFIT. I UNDERSTAND THAT I MAY NOT CHANGE THIS ELECTION UNTIL NEXT OPEN ENROLLMENT TO BE EFFECTIVE JANUARY 1st OF THE NEXT CALENDAR YEAR UNLESS I HAVE A QUALIFYING EVENT.

EMPLOYEE SIGNATURE:		DATE:	

OPTIONAL COVERAGE
(Not Available if No Co-Pay is Selected)

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT
PAYROLL DEDUCTION IS $5.60 FOR OPTIONAL INSURANCE

THE BASIC LIFE INSURANCE AND ADDITIONAL LIFE INSURANCE AMOUNTS REDUCE AFTER AGE 65.
(See the Benefits Program brochure section of the Summary Plan Description for details about the reductions.)

☐ **I AM APPLYING FOR OPTIONAL COVERAGE**

☐ **I AM NOT APPLYING FOR OPTIONAL COVERAGE**

BENEFICIARY DESIGNATION

(This will supersede any previous designation(s) of beneficiary.)
Please note that beneficiary percentage designations must total 100%.
You may also use this section to change your beneficiary.

☐ **CHANGE OF BENEFICIARY ONLY**

PRIMARY BENEFICIARY #1					
First Name		**Middle Initial**		**Last Name**	
Address					
City, State, Zip				**Benefit %**	
Relationship:		**Birthdate**	/ /	**SSN**	

PRIMARY BENEFICIARY #2					
First Name		**Middle Initial**		**Last Name**	
Address					
City, State, Zip					
Relationship:		**Birthdate**	/ /	**SSN**	

PRIMARY BENEFICIARY #3						
First Name		Middle Initial		Last Name		
Address						
City, State, Zip				Benefit %		
Relationship:		Birthdate	/ /		SSN	

CONTINGENT BENEFICIARY #1 (If Primary Beneficiary is Deceased)						
First Name		Middle Initial		Last Name		
Address						
City, State, Zip				Benefit %		
Relationship:		Birthdate	/ /		SSN	

CONTINGENT BENEFICIARY #2 (If Primary Beneficiary is Deceased)						
First Name		Middle Initial		Last Name		
Address						
City, State, Zip				Benefit %		
Relationship:		Birthdate	/ /		SSN	

CONTINGENT BENEFICIARY #3 (If Primary Beneficiary is Deceased)						
First Name		Middle Initial		Last Name		
Address						
City, State, Zip				Benefit %		
Relationship:		Birthdate	/ /		SSN	

PLEASE READ THE FOLLOWING CAREFULLY

1) I request the coverage specified above under the United Food & Commercial Workers MED 1000 Health & Welfare Plan and authorize my employer to deduct from my earnings any required contributions.

2) I understand that this election form cannot be changed during the plan year, unless the revocation and new election are on account of and consistent with a change in family status (i.e. marriage, divorce, death of a spouse or a child, birth or adoption of a child.)

3) I understand that this election form shall replace and supersede any previous requests for coverage and/or designation of beneficiary.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

To obtain more information, contact NEBA, Inc. at (800) 567-5899.