

**CHOICE PLAN 2010**  
**Choice Benefits Enrollment Form**  
(C48/1232/1626)

Participant Name (please print)					Social Security #	
Participant Address:	Street	Apt. #	City	State	Zip Code	
Date of Birth	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				

**Your Medical Plan Options**

Each option is shown below. After reading your Enrollment Handbook check the options you want.		
<b>Check One</b>		
<input type="checkbox"/> Dual Income Option A * (Waive medical for family) <b>You receive \$200/month in Benefit Credits</b>	<input type="checkbox"/> Dual Income Option B * (Waive medical, prescription, vision, and dental for spouse) <b>You receive \$125/month in Benefit Credits</b>	<input type="checkbox"/> Dual Income Option C* (waive medical for spouse) <b>You receive \$100/month in Benefit Credits</b>
* If you choose this option, complete the Proof of Other Coverage Form and return with this form.		

**Your Choice Benefit Options**

<b>Retirement 401(k) Plan Account</b>	
Enter the amount of benefit credits you want to contribute to the Retirement 401(k) plan in the column on the right. If you choose this option, complete and sign the separate 401(k) enrollment and beneficiary forms.	\$ _____ /mo
<b>Paid Time Off Bank (Taxable Income)</b>	
Enter the amount of benefit credits you want to contribute to the Paid Time Off Bank.	\$ _____ /mo
<b>Extended Eligibility Bank</b>	
Enter the amount of benefit credits you want to contribute to the Extended Eligibility Bank in the column to the right (minimum \$200)	\$ _____ /mo
<b>Health Care Spending Account</b>	
Enter the amount of benefit credits you want to contribute to the Health Care Spending Account. (max \$500)	\$ _____ /mo
<b>Supplemental Life Insurance</b>	
Choose the amount of Supplemental Life Insurance: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Enter the amount of benefit credits needed to buy your chosen amount. See the Choice Plan Enrollment brochure for the cost of each amount.	\$ _____ /mo
<b>Total Benefit Credits</b>	
\$ _____ /mo	

**Authorization** - My signature below indicates that I have read and understood this Election Form and the descriptive materials made available to me by the UFCW Local 1776 and Participating Employers Health and Welfare Fund. I understand that these elections will remain in effect until the next annual enrollment period unless I have a qualified change in family status. I certify that the information on this form is complete and accurate to the best of my knowledge. **I understand that if this information changes in the future, I am obligated to notify the Fund Office within 30 days. Failure to do so may affect benefit coverage.**

Participant Signature	Date Signed
-----------------------	-------------

**\*\*\*Please contact Daneen Farina at 1-800-458-8618 ext 119 if you should have any questions\*\*\***