CHOICE PLAN 2006
Choice Benefits Enrollment Form

Participant Name (please print) Social Security #

Participant Address: Street Apt. # City State Zip Code

Date of Birth	Sex: □ Male □ Female	Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Your Medical Plan Options

Each option is shown below. After reading your Enrollment Handbook check the options you want.	
Check One	
□ Personal Choice **You receive no benefit credits**	□ Dual Income Option * **You receive $150 per month in benefit credits**
* If you choose this option, complete the Proof of Other Coverage Form and return with this form.	

Your Choice Benefit Options

Retirement 401(k) Plan Account	
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.	$_____
Paid Time Off Bank (Taxable Income)	
Enter the amount of benefit credits you want to contribute to the Paid Time Off Bank.	$_____
Extended Eligibility Bank	
Enter the amount of benefit credits you want to contribute to the Extended Eligibility Bank in the column to the right (minimum $200)	$_____
Health Care Spending Account	
Enter the amount of benefit credits you want to contribute to the Health Care Spending Account. (maximum $500)	$_____
Total Benefit Credits **BE SURE YOUR TOTAL EQUALS $1,800**	**$1,800**

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 NOTE: This election involves your **MEDICAL** plan only and does not change or otherwise affect any other benefits for which you are eligible. Please contact a UFCW Local 1776 & Participating Employers Health & Welfare Fund representative at 800-458-8618 if you should have any questions.

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