UFCW Local 1776 and Participating Employers Health and Welfare Fund

2004 Other Prescription Drug Benefit Information

Participant's Name ______________________ SS# ______________________

Employer ____

Spouse Name ______________________ SS# ______________________

Do you have another job for which you are covered for prescription benefits? ☐ Yes ☐ No

If yes, please complete the following

Carrier ______________________ (NPA, for example) ID# ______________ (Usually SS#)

Group No. ______________________ Employer ______________________

Does your spouse have other prescription coverage? ☐ Yes ☐ No

If yes, please complete the following

Carrier ______________________ (NPA, for example) ID# ______________ (Usually SS#)

Group No. ______________________ Employer ______________________

Does your spouse have dependent coverage under his/her prescription plan? ☐ Yes ☐ No

I hereby certify that this information is true and complete to the best of my knowledge, and I understand that my failure to accurately respond to the questions above can result in the loss of my eligibility for coverage under the UFCW Local 1776 and Participating Employers Health and Welfare Fund.

Kindly sign and return this form in the envelope provided. Thank you.

Signature ______________________ Date ______________________

If you have internet access, please provide us with your e-mail address

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