UFCW Health and Welfare Fund of Northeastern Pennsylvania

PLEASE USE THE REVERSE SIDE OF THIS FORM TO ADD AND/OR DROP ADDITIONAL DEPENDENTS.

Dependent "Add" or "Drop" Form

VERSION: Hanover OE 11/7/25

If you wish to add or drop a dependent under your coverage, you must complete this form and return it to the Fund Office for receipt by **November 28, 2025**. Dependents whom you elect to drop from your coverage will be terminated from all Fund benefits. **NOTE: Your next opportunity to make changes to the dependents covered under your benefits will be during the next Open Enrollment period, unless you experience a Qualifying Life Event[1] of which you must notify the Fund Office within 30 days**.

Add the Following Dependent(s) to My Coverage

1	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
2	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
3	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		

Drop the Following Dependent(s) From My Coverage

1	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
2	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
3	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		

I Understand That:

- If I waive dependent coverage, the Fund will not provide any primary, secondary, or other coverage for, or in place of, the coverage waived;
- If I add a dependent, I must provide the Fund Office with a copy of the marriage certificate for a spouse or the birth certificate for a child; and
- My dependent will not be added to my coverage unless and until I provide the applicable documentation and other information required.

Participant Signature: _____ **Date:** _____

Participant Name: _____ **Last 4 Digits of SS#:** _____

(Print here)

[1] A Qualifying Life Event is defined as:

- A change in your marital status (marriage, divorce, or death of a spouse)
- A change in the number of your dependents (birth, adoption or placement for adoption, or death of a dependent)
- A change in your dependent's eligibility status because of age
- A change in employment status, work site, or work schedule of an employee or dependent that results in a gain or loss of eligibility for health coverage (including a switch between full-time and part-time)

Add the Following Dependent(s) to My Coverage

4	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
5	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
6	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
7	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
8	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
9	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
10	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		

Drop the Following Dependent(s) From My Coverage

4	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
5	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
6	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
7	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
8	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
9	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		
10	Full Name:	Social Security Number:	Date of Birth:
	Relationship: ☐ Spouse ☐ Child ☐ Stepchild ☐ Other *(Describe)*:		