UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

Salus University

Dependent "Add" or "Drop" Form

If you wish to add or drop a dependent from your Fund coverage effective August 1, 2023, you must complete this form and return it to the Fund Office for receipt by **July 21, 2023**. 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 2024 Open Enrollment, for changes effective as of January 1, 2024, unless you experience a Qualifying Life Event[1] of which you must notify the Fund Office within 30 days.

❖ **I wish to ADD the following dependents to my coverage:**

1. Dependent's Name:_____ SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

2. Dependent's Name:_____ SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

3. Dependent's Name:_____ SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

[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 status)

❖ **I wish to <u>DROP</u> the following dependents from my coverage:**

1. Dependent's Name:_____SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

2. Dependent's Name:_____SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

3. Dependent's Name:_____SS#: _____

   Dependent's Date of Birth: _____

   Relationship:
   - o Spouse
   - o Child
   - o Stepchild
   - o Other (Describe relationship): _____

- I understand that if I wish to reinstate the dependent coverage waived on this form due to a Qualifying Life Event, I must notify the Fund Office within 30 days of that event.
- I understand that unless I have a Qualifying Life Event, I may not reinstate the dependent coverage waived on this form until the next Open Enrollment period.
- I understand that if I add a dependent, I must provide the Fund Office with a copy of my marriage certificate for a spouse, or birth certificate for a dependent child.

Participant Name (print):_____

Participant Signature:_____**Date:**_____

Participant Last 4 Digits of SSN: *-***-**_____