



November 16, 2011

To Shelly's Medication Services and RxDN, Inc. Participants Eligible for Health Benefits

RE: Spousal Surcharge for Health Coverage

Dear Participant:

As a result of negotiated changes between the UFCW Local 1776 Union and Shelly's Medication Services and RxDN, Inc., the Fund is implementing a surcharge for spousal coverage effective January 1, 2012. This means that, if health insurance coverage is available to your spouse from another source, and that coverage costs \$125 per month or less, you will be charged a \$50 per month contribution to have your spouse covered by the Fund as your dependent.

You can request to obtain a waiver of the spousal surcharge if (a) your spouse has other coverage that costs more than \$125 per month; or (b) your spouse does not have other coverage available to him/her.

To request a waiver of the surcharge, complete the enclosed Spousal Surcharge Waiver Form, and return it to the Fund Office by December 16, 2011. To ensure continued coverage for all Fund participants and to protect these benefits, please make certain that the information you submit is complete and accurate. If this form is not returned to the Fund Office by the date specified, and your spouse is enrolled as your dependent on the Fund's coverage, we will assume that your spouse has other coverage that costs less than \$125 per month and you will be charged a \$50 per month contribution from your paycheck beginning January 1, 2012.

Reminder! Please consider all of your options for the 2012 plan year. If you are eligible to enroll in the Choice Plan, the Dual Income Option C allows YOU and your eligible dependent children to REMAIN COVERED by the Fund, while you WAIVE YOUR SPOUSE'S medical coverage provided by the Fund. Additionally, your spouse will be provided with supplemental wrap-around coverage of up to \$6,500 per year, and you can earn Benefit Credits for not enrolling your spouse. The amount of Benefit Credits you earn is \$1,200 per year. The Benefit Credits earned can be taken in cash through the Paid Time Off option, or can be deposited into your Retirement 401(k) Plan, Healthcare Spending Account, and/or an Extended Eligibility Bank.

Should you have any questions regarding the spousal surcharge or the Choice Plan, please do not hesitate to contact the Fund Office by phone at 610-941-9400 or toll free at 1-800-458-8618, or via e-mail at fund@ufcw1776benefitfunds.org.

Sincerely,
The Fund Office Staff

Enclosure

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Spousal Surcharge Waiver Form

If you would like to cover your spouse under the UFCW Local 1776 and Participating Employers Health and Welfare Fund, there is a monthly \$50 surcharge. The surcharge may be waived if the coverage that is available to your spouse costs more than \$125 per month or your spouse does not have other coverage available to them. In order to have the surcharge waived, you must complete this form.

Participant Name: _____ Social Security Number: _____

I am requesting waiver of the spousal surcharge for the following reason (check all boxes that apply):

- My spouse is not employed.
- My spouse is employed, but does not have health insurance coverage available through his/her employer.
- My spouse is employed, but the health insurance coverage available to him/her exceeds \$125 per month.

In order for the waiver to be processed, all applicable information listed below must be completed:

My spouse is:

- A Temporary/Part-Time employee who is not eligible for health insurance
- Employed, but not currently entitled to health insurance coverage until _____
- Employed, but employer does not offer any other health insurance coverage
- Self Employed and does not have health insurance coverage
- Employed, but cost of coverage is \$ _____/month
- Other w/ reason: _____

Spouse's Name:	
Employer's Name:	
Employer's Address:	
Employer's Phone Number:	
If Self Employed, Business Tax ID #: (If Social Security Number used instead of Tax ID, so indicate)	

I declare that this information is true and correct to the best of my knowledge, information and belief. I understand that by completing this form, I am requesting a waiver of the spousal surcharge for health insurance and am aware that I may be requested to provide additional documentation at any time for the waiver. I also understand that should a change occur with my spouse's eligibility for health coverage, I must promptly notify the Fund at 610-941-9400 or toll free at 1-800-458-8618. I understand that the UFCW Local 1776 and Participating Employers Health & Welfare Fund reserves the right to suspend or terminate my group health coverage if it concludes that I have provided false or misleading information in this waiver.

Participant Signature

Date