Dear Participant:

Please complete the Fringe Benefit Enrollment Form on the reverse side and return it to our office. This form must be *signed and dated in order to be valid*.

The following documentation is ***required*** for you and your eligible dependent(s).

Married- Please provide a copy of your state issued marriage certificate.

Children – Please provide a copy of each child's state issued birth certificate along with adoption papers if adopted.

Stepchildren, please provide a copy of each dependent's state issued birth certificate along with applicable documentation (i.e. spouse's divorce decree, court documents)

Divorce – Please provide a copy of your divorce decree.

Legible Copies of Social Security Cards - for yourself and each of your eligible dependent(s).

Under the Affordable Care Act (ACA), all individuals are required to maintain health insurance coverage. The Plan is required to provide you with a 1095B form detailing who in your family has received coverage from the Welfare Fund. The IRS requires an exact match on the spelling of each name and Social Security number, as indicated on the Social Security cards for you and each of your eligible dependents. If there is any deviation, the IRS will reject the submission of your 1095 B information. ***Failure to provide correct information could result in the IRS accessing penalties to you when you file your income taxes.***

Should you have questions relative to completing this form or the documentation required, please feel free to contact our enrollment department at 1-800-792-3666 extension 6005.

Return completed form with documentation to:

I E Shaffer & Co
PO Box 1028
Trenton NJ 08628

ENROLLMENT FORM
UAW Group Health and Welfare Fund
LOCAL 2326
PRINT ALL INFORMATION

-- --

Last Name *First Name* *M.I.* *Social Security Number*

Home Address *City* *State* *Zip*

Home Phone # *Cell #* *E-mail Address*

Date of Birth *Gender* *Marital Status: (Circle One)* *Single* *Married* *Divorced* *Widowed*

List Below Names of Your Spouse and All Dependent Children (up to age 26)
List Names in Order of Age – Oldest First

		Social Security No.	Relationship			Date of Birth		
			Spouse	*Son*	*Daughter*	*Month*	*Day*	*Year*
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							

Welfare Fund Beneficiary Designations
(If applicable)

I hereby authorize the payment of any death benefits as follows:

Primary *Contigent*

Name(Last, First, MI) Name(Last, First, MI)

Address Address

SSN *DOB* *Relationship* *SSN* *DOB* *Relationship*

Signature of Employee Date

UAW HEALTH & WELFARE FUND LOCAL 2326
COORDINATION OF BENEFITS FORM

PRINT ALL INFORMATION

Participant Last Name _____ Participant First Name _____ M.I. _____ Social Security Number _____

Home Address: _____

City _____ State _____ Zip code _____ Phone # _____

Please check here, sign and date below if no family members have medical/dental coverage ☐

Complete the following section for each family member and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if member/dependent has other medical/dental coverage	Type of coverage- family/single/ parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Participant		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Spouse		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

_____ Participant Signature

_____ Date

UAW HEALTH & WELFARE FUND LOCAL 2326
COORDINATION OF BENEFITS FORM
PRINT ALL INFORMATION

Participant Last Name ________ Participant First Name ________ M.I. ________ Social Security Number ________

PAGE 2 - ADDITIONAL CHILDREN

Complete the following section for each child and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if dependent has other medical/dental coverage and effective date	Type of coverage-family/single/parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

________ Participant Signature ________ Date