IMPORTANT FORMS!!!

COMPLETE THE REMAINING PAGES

AND

RETURN TO THE ADMINISTRATIVE OFFICE

661 North Ericson Rd.
Cordova, TN 38018
Fax: (901) 758-3021

TIME SENSITIVE

Forms to include any "Required Documents" will not be returned to sender. Do not mail originals.

Ancillary Benefits Enrollment Application

Dear Participant:

According to our records you may be eligible for Ancillary Benefits as a new enrollee.

If you are eligible, Ancillary Benefits, also known as supplementary benefits include dental, vision and life insurance. These benefits are offered to new enrollees who average between 12-18 hours per week at a cost of $5 per week.

Please complete and return these forms to the fund office within 60 days of your eligibility date, the date your employer makes a contribution for you.

EMPLOYEE'S INFORMATION

First Name	Last Name	Social Security #	Date of Birth

Mailing Address (Street)	City	State	Zip Code

Gender MALE / FEMALE	Phone Number	Email Address	Name of Employer(s)	

Dear Plan Administrator:

I have received notice of my eligibility for Ancillary Benefits as a new hire enrollee.

I understand that Ancillary Benefits offered are dental, vision and life insurance at a cost of $5.00 per week if I am eligible. By signing this notice, **I wish to enroll in Ancillary Benefits.**

I understand that ongoing eligibility for this coverage requires maintaining an average of 12 hours of work per week.

I am returning my enrollment form within 60 days of my eligibility date.

Sincerely,

_____ _____

Signature Date

_____

Printed Name

UFCW Local 1529 and Employers H&W Plan & Trust
Administrative Consulting Services of Tennessee, Inc.
661 North Ericson Road
Cordova, TN 38018
Fax 901-758-3021

Upload forms/documents at www.bams.bz

OTHER INSURANCE COVERAGE QUESTIONNAIRE FORM

Do you or ANY of your dependents have any other medical or dental coverage? This includes any state plans, Veteran plans, Medicare or Medicaid: **YES____ OR NO_____** If you marked YES, which indicates you or a dependent has other coverage, complete the **ENTIRE** section below and submit the supporting documentation outlined at the bottom of this page:

Name of the Policy Holder (the person who has the other insurance):_____

1. Benefits Included in Other Coverage: Medical ☐ Dental ☐ Vision ☐
2. Policy Holder's Relationship to covered persons: Spouse ☐ Parent ☐ Step-Parent ☐
3. Policy Holder's Date of Birth (other insurance carrier): ___/____/___
4. Name of Dependent(s) covered by other insurance carrier:_____
5. Name of Other Insurance Carrier (Example: MS Medicaid/Aetna/Blue Cross Blue Shield):_____
6. Policy Number:_____ Policy Effective Date ____/____/_____Policy Termination Date ____/____/_____
7. Name of Employer the insurance is provided by (Example: FedEx, Nike Corp., McDonald's)_____ Date of Hire with this Employer_____
8. Is there a court order regarding health care coverage for your children? Yes_____ No_____
9. If you answered "Yes" please supply us with a copy of the Medical Child Support Order.
10. If there is not a courts order, who has custody of children? _____
11. Has the custody parent remarried? Yes____ No____,
12. If Yes does the step-parent have family insurance coverage? Yes_____ No_____,
13. If Yes is anyone on your policy covered by the step-parent's policy? _____
14. Biological Father's Date of Birth: _____ Biological Mother's Date of Birth:_____
15. List the children the above information applies: _____

MEDICARE ONLY (complete below if you have Medicare Part A, B or D or any advantage plan through Medicare)

If Medicare ☐ Part A ☐ Part B ☐ Part D Medicare Effect Date: ____/____/_____ **Medicare HICN: _____**

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease

Are you or any of your dependents covered under Medicare due to kidney failure? ☐ Yes ☐ No
If yes, when did kidney dialysis begin? ____/____/_____

Additional Supporting Documentation You Must Submit: If you or your dependents have had other insurance coverage with another carrier within 12 months of this application, you must contact that carrier and request a "**Certificate of Credible Coverage**" and submit that to our office. Additionally, if we have on file that you do have other coverage and you no longer have it, you will also need to submit a Certificate of Credible Coverage that reflects the termination date under the other policy. Lastly, please attach a copy of that carriers "Coordination of Benefits Rules."

Attest: I have read the above and attest that statements made by me on this form are complete and true. I understand that if any of the above information changes it is my responsibility to notify the Plan Administrator in writing immediately. I understand the definition of Fraud and know that if I willingly falsify this document that I can be prosecuted for Health Care Fraud.

Signature: _____ Date: _____

Beneficiary Form for Death Benefit

See the Plan's SPD for all terms related to the Death Benefit and Accidental Death and Dismemberment Benefit. This form will be used to pay the employee's life benefits to the beneficiary assigned on the form.

Employee Name: (First) _____ (Middle Initial) _____ (Last Name) _____
Social Security No._____-_____-_____ Telephone # (___) _____--_____ Email: _____

Address: (No. and Street) _____, (City) _____, (State and Zip Code) _____

Date of Birth: _____/_____/_____ Gender: _____

I, the undersigned, hereby revoke all prior beneficiary designations made by me and hereby direct that any benefits payable under the Fund upon my death be payable to the following primary beneficiary(ies). In the event my primary beneficiary (or all my primary beneficiaries) die or disclaim the benefit the full number of benefits, if any, has been paid, I direct that my entire remaining interest in the Fund be paid to the following contingent beneficiary(ies). This beneficiary designation is effective when received by the Fund Office. If additional beneficiaries are needed, please attach a separate page listing the names and percentage amount.

YOUR BENEFICIARY IS THE PERSON OR PERSONS YOU WISH TO RECEIVE YOUR LIFE INSURANCE PROCEEDS.
PLEASE DO NOT NAME YOURSELF

Life Insurance Beneficiary	Name	Relationship & Date of Birth	Telephone #	Percentage
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				

Unless otherwise provided where two or more beneficiaries are named the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes all previous designations. The right to further change the beneficiary is reserved unto the insured.

Signature of Employee_____ **Date** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Policy Holder's Name:_____ Policy Holder's ID or SSN:_____
Phone Number:_____ Email Address:_____
Initial if you would like to Opt-In to receiving email and or text communication from the Fund _____
Authorizing Party (Print Name of Person Completing Authorization):_____

IMPORTANT! Without this form on file, completed by you we cannot disclose any of your personal health information (PHI) to any party.

The undersigned (or his or her Personal Representative identified below), hereby authorizes the use or disclosure of my health information or the health information of my minor dependent child (identified below) as described in this authorization. Name specific person/organization authorized to provide information: **ACST, Inc. on behalf of UFCW and Employers H&W Plan and Trust**

Name specific person/organization **authorized to receive** and use this information; (You must list each person by name. In example, possible persons would include your spouse, parent, employer, attorney).

Authorized Person (s)	Relationship (spouse/employer/attorney/parent…)

INFORMATION TYPES: Initial below to indicate information to be disclosed:

___Provider/Facility Name
___Explanation of Benefit Payment Details
___Diagnosis & Procedure Codes
___Nature of Injury or Illness
___Date Services Rendered
___Performed Procedure
___Lack of Claim Payment
___Benefit Eligibility
___Medical Records (If applicable)
___Other, please list if applicable: _____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____/_____/_____. (Must be valid date ex: 12/31/2030)

OR Initial Box for the date to be UPON TERMINATION OF ENROLLMENT IN THIS HEALTH PLAN ☐

REVOCATION: I understand that I have the right to revoke this authorization at any time by notifying ACST, Inc. in writing. I understand that the revocation is only effective after it is received and logged by ACST, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information has been disclosed, federal law might not protect it and the recipient might disclose it again. I understand that I am entitled to receive a copy of this authorization, a copy shall be considered as valid as the original.

Signature of Individual _____Date_____/_____/_____.
Name of Minor Dependent, if applicable_____ _____

Name of *Personal Representative, if applicable_____ _____
Signature of Personal Representative_____Date_____/_____/_____.

*If a Personal Representative executes this form, that representative warrants that he/she has the authority to sign the form and a copy of the written document that legally authorizes them to act in your behalf must be attached to this form.

Without a valid Authorization, none of your Protected Health Information can be released to anyone outside of a Covered Entity, not even to a spouse. NO EXCEPTIONS.

DENTAL BENEFITS

DENTAL GENERAL

Deductible amount per Calendar Year per Eligible Person ……..$50.00
Maximum dental benefits per Calendar Year per Eligible Person……$1,500.00

DENTAL FEE SCHEDULE

This Plan pays on a Dental Fee Schedule; each covered service (code) has a set allotted amount payable under the Plan. The fee schedule pays at the 80th percentile (NOT 80%). This means that 80% of local dentists will accept this payment as payment in full. To know what your patient responsibility will be after your co-pay of $50 has been met, you will subtract the billed amount for each service from the allowed amount. A copy of the Dental Fee Schedule is available at www.bams.bz. Participants of the Plan can request a copy by calling the benefits office.

DENTAL NETWORK – Shared Administration with Cigna

The Fund will be participates in the **Shared Administration,** Preferred Provider Network (PPO), through **Cigna Dental. You can go to any dentist you choose however you can realize better savings which will extend the life of your benefit if you go to dental provider that is in network with Cigna.**

To locate a participating network dentist – you may call 1-800-797-3381 or go to www.cignadentalnetworksolutions.com

DEATH BENEFIT (For Employees Only)

Amount of Death Benefit $10,000

VISION PLAN BENEFITS

Vision care benefits are provided through Group Vision Services / EyeMed

Customer Service at 1-866-265-4626, to view benefits or locate a provider. Important! Members will be responsible to pay the provider at the time of service for any applicable copayment /costs that exceed the plan coverage.

Benefits from a GVS/EyeMed Network Provider*		Copayment
Vision Examination – includes dilation as indicated	**Once Every 12 Months***	**$ 0.00**
Eyeglass Lenses - single vision, bifocal, or trifocal in standard/basic plastic **w/Standard Scratch Resistance**	**Once Every 12 Months***	**$ 0.00**
Frame –covered in full up to a **$ 135.00 retail value**. Members receive 20% off balance for selection costing more than the plan allowance	**Once Every 12 Months***	**N/A**
Contact Lenses - in lieu of spectacle lenses (does not include fitting and follow-up) • **Elective** – Disposable or Conventional, covered in full up to **$ 130.00 A**llowance. Conventional lenses: members receive 15% discount off balance over plan allowance. • **Medically Necessary** – Covered in full up to **$ 250.00**	**Once Every 12 Months***	**N/A**

Out of Network Benefits – If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. Members will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule.

Member Reimbursement for services/materials obtained from an Non-Network Provider	
Vision Examination	Up to $ 32.00
Lenses	
Single Vision	Up to $ 30.00
Bifocal	Up to $ 45.00
Trifocal	Up to $ 75.00
STD. Scratch Resistance	Up to $ 12.00
Frame	Up to $ 57.00
Elective Contact Lenses (in lieu of spectacle lenses)	Up to $105.00
Medically Necessary Contact Lenses	Up to $200.00

***In-network services and materials may be subject to a copayment at the time of service. **Out-of-Network amounts are maximum reimbursable amounts paid to members after the claim is filed. Amounts may vary by state.**

Additional Savings Program: Pricing available in conjunction with funded benefits.

Lens Options	Member Pricing	Other Options/Services	Member Pricing
Tint (solid & gradient)	$15.00	Other Lens Add-Ons and Services	20% off Retail
UV Coating	$15.00	Additional Complete Pair Purchases ***	40% off Retail
Standard Scratch Resistance*	**Covered**	Conventional Contact Lenses	15% off Retail
• Standard Polycarbonate . Adult	$40.00	Premium Contact Lens Fitting and Follow-up	10% discount
Children	$40.00		
Standard Anti-Reflective	$45.00	Standard Contact Lens Fitting and Follow-up	$40.00
Standard Progressive Lens**	$65.00	Retinal Imaging	$39.00
Premium Progressive Lens**	20% off Retail	EPIC Hearing Aid Savings Program	Fixed fee schedule

** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Members are responsible for the lens copayment and any additional charges.

LensCrafters
Sears Optical
Pearle Vision
JCPenney jcp.com
Target Optical
Private Practitioners

To access the Hearing aid savings plan contact:
EPIC Hearing Healthcare
877-606-3742
Website is located at: www.epichearing.com

epic

VISION PLAN LIMITATIONS AND EXCLUSIONS

- Orthoptist or vision training, subnormal vision aids and any associated supplemental testing; Aniseiikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures
- Any corrective eyewear, required by a policyholder as a condition of employment, safety eyewear, services provided as a result of any Worker's Compensation law, or similar legislation or required by any governmental agency or program whether federal, state or subdivision thereof
- Plano (non-prescription) lenses; non-prescription sanglasses
- Two pair of glasses in lieu of bifocal
- Services or materials provided by another group benefit plan providing vision care
- Services rendered after the date an insured ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered and the services rendered to the insured are within 31 days from the date of such order
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
- Certain frame brands in which the manufacturer imposes a no-discount policy
- Covered benefits may not be used in conjunction with coupons or other provider discount offers

If an Insured and the Insured Spouse are both Insured by the plan, one Insured party may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured