SOUTHERN CALIFORNIA UNITED FOOD & COMMERCIAL WORKERS UNIONS AND DRUG EMPLOYERS DRUG TRUST FUNDS
2220 HYPERION AVENUE, LOS ANGELES, CALIFORNIA 90027
TEL (323) 666-8910 FAX (323) 663-9495 www.ufcwdrugtrust.org

DO NOT RETURN THIS FORM IF YOU ARE NOT CHANGING YOUR COVERAGE

Revocable Authorization for Payment of Retiree Health Premium

As you know, your Retiree health benefits are provided by the United Food & Commercial Workers Unions and Food Employers Benefit Fund ("Food Benefit Fund"). If you wish to have the monthly premium for your Retiree Health benefits deducted from your monthly pension and paid to the Food Benefit Fund, you must complete this premium deduction authorization (the "Authorization").

I hereby authorize and direct the Southern California United Food & Commercial Workers Unions and Drug Employers Pension Plan ("Drug Pension Plan") to deduct the premium cost for the coverage(s) I have elected from my monthly pension benefit, and to pay this amount directly to the Food Benefit Fund on my behalf.

The monthly amount to be deducted is *(check the appropriate boxes for the coverage(s) you select):*

Retiree-only Coverage:

☐	I am eligible for Medicare (1 Medicare)	**$ 67.06**
☐	I am not eligible for Medicare (0 Medicare)	**$167.06**

OR

Family Coverage:

☐	Neither my spouse/domestic partner nor I am eligible for Medicare (0 Medicare)	**$335.32**
☐	Either my spouse/domestic partner or I am eligible for Medicare (1 Medicare)	**$234.72**
☐	Both my spouse/domestic partner and I are eligible for Medicare (2 Medicare)	**$134.12**

ADD

☐ **Dental Coverage** (for you and your enrolled family members) **$93.00**

I understand if I elect to participate in the Dental Plan, coverage for my eligible dependents is included, even if they are not enrolled in the Retiree Health Plan.

OR

Decline participation:

I decline coverage in the United Food & Commercial Workers Unions and Food Employers Benefit Fund's (If you decline to enroll in medical coverage you may not re-enroll until the third Open Enrollment following your decline. If you decline to enroll your spouse/domestic partner, you may not enroll them until the third Open Enrollment following you decline.)

☐ Retiree Health and Dental Plans.

☐ Retiree Dental Plan only and enroll or remain enrolled in the Retiree Health Plan.

If there is a change to the amount of monthly premium required to maintain the coverage(s) I have elected, this Authorization will remain in effect, and the Drug Pension Plan is directed to deduct the new premium amount for the coverage(s) elected and pay that amount to the Food Benefit Fund. I understand that I have the right to revoke this Authorization at any time, and that my revocation will apply prospectively (to pension benefits that have not yet been paid). I further understand that if I choose to revoke this Authorization, or if the monthly premium is more than the amount of my monthly pension benefit, I will have to self pay the premiums.

This Authorization is to remain in full force and effect until I notify the Drug Pension Plan in writing of any changes or until my monthly pension benefit is no longer sufficient to cover the cost of the coverage(s) elected.

Signature_____ Date_____

Name (print)_____ SSN#_____

Phone Number_____