Southern California
United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC
6425 Katella Avenue, Cypress, CA 90630-5238
P.O. Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 • 877-284-2320
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Application for Reinstatement of Eligibility

You must complete and submit this form within 30 days to reinstate your eligibility; otherwise, you may not be eligible for retroactive coverage. Your Employer has reported that you did not work enough hours to earn eligibility for Health and Welfare Benefits provided under the Fund. Your current eligibility will terminate on the "Loss of Eligibility" date listed on the *Notice of Qualifying Event for COBRA Continuation Coverage.* If you DID work additional hours or earn hours as a result of vacation, family leave, workers' compensation, or personal disability, please complete the information below and provide the Fund with confirming documentation, so that we can determine your eligibility.

PARTICIPANT INFORMATION

Supply all information requested below. Please print clearly.

Last Name	First Name	Mid. Initial	Fund ID	Social Security Number

Mailing Address Street:	City	State	Zip Code	Date of Birth (mm/dd/yyyy)

Home phone	Email Address	Employer	Local #
Mobile phone		Date of Hire (mm/dd/yyyy)	

☐ I was on paid vacation from **(mm/dd/yyyy)**_____ to **(mm/dd/yyyy)**_____

Anniversary month in which vacation hours were paid to you _____.
You will be responsible for any contributions to premium not withheld during the coverage month, to be withheld in future months up to twice the amount of your standard deduction.

☐ I was on approved Family Leave - Please submit a copy of Employer's approval letter as verification.

☐ I collected:_____ State Disability_____Workers' Compensation for the period from _____ to _____

You must submit proof of payments from the CA Employment Development Department (EDD) or workers' compensation (WC) carrier as proof of disability. Employees covered under Platinum or Platinum Plus benefits may be entitled to extend coverage up to 6 months for your own illness or injury or up to 12 months for a WC disability. At the end of your extended eligibility period, if unable to return to work, you may elect to enroll in COBRA to continue your coverage. **Save the COBRA notice you were mailed (or that is enclosed) to ensure timely enrollment.** You **MUST** submit payment for your contribution to premiums that would have been withheld from your paycheck(s) during any weeks missed. If you are covered under Silver or Gold Benefits, proof of EDD Benefit or workers' compensation payment is required to prevent a break in service.

☐ I failed to work the minimum monthly hours because I was scheduled less than my weekly guarantee in a holiday week.

Date of Holiday_____

Submit payroll stubs as verification.

☐ I worked the required straight-time hours during workweeks in the month(s) below:

Hours worked _____ Dates: from _____ to _____.

Hours worked _____ Dates: from _____ to _____.

Submit payroll stubs as verification. NOTE: The standard workweek in the Industry is Monday through Sunday. Your monthly hours are credited to you as of the last Sunday of each month.

☐ I returned to work on _____ following a maternity leave of absence.
Attach pay stubs for the month you returned to work and the following month.

☐ I returned to work on _____ following a military leave of absence.
If discharged, attach a copy of your DD214.

If serving in a reserve component of the U.S. Armed Forces, attach copies of your separation from active duty showing the dates you served.

I understand that I will owe contributions to premium for each week they could not be withheld by my Employer.

Participant's Signature _____ Date _____