Southern California United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC

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Benefits+
Your Trusted Benefits Partner

Retiree Premium Authorization

RETIREE'S INFORMATION

First Name | Last Name | Fund ID | Social Security #

Address | Apt./Unit# | City | State | Zip

Home Phone | Cell Phone | Email

☐ I elect to participate in the Benefit Fund Retiree Health Plan and pay the applicable premium. ***If you are currently enrolled in the Plan, your coverage will continue unless you decline coverage. You may decline medical and/or dental coverage on the Enrollment for Retirees form.***

☐ I elect Single coverage for myself only. (Coverage for eligible dependent children is included.)

☐ I elect Family coverage for myself and my spouse/domestic partner. (Coverage for eligible dependent children is included.)

Type of Coverage	Medicare Eligibility	Monthly Contribution
Single	You are not Medicare eligible (0 Medicare)	$185.81
Single	You are Medicare eligible (1 Medicare)	$74.32
Family	Neither you nor your spouse/domestic partner is Medicare eligible (0 Medicare)	$371.62
Family	Either you or your spouse/domestic partner is Medicare eligible (1 Medicare)	$260.13
Family	Both you and your spouse/domestic partner are Medicare eligible (2 Medicare)	$148.64

Every year on April 1st, the Retiree Medical premium rates will be adjusted by the same percentage as the Medicare Part B rates.

☐ I decline to participate in the United Food & Commercial Workers Unions and Food Employers Benefit Fund ("Benefit Fund") Retiree Health Plan. ***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 your decline.*** *Should you or your spouse/domestic partner lose other group health insurance, you, or you and/or your spouse/domestic partner may enroll in this Plan without waiting for the third Open Enrollment, provided you request enrollment within 120 days after your other coverage ends.* I understand that if I decline to participate in the Benefit Fund Retiree Health Plan, I will not be covered by the Fund's Death Benefit.

☐ I elect to participate in the Benefit Fund Retiree Dental Plan. The premium is $85.00 per month. I understand that I must be enrolled in the Medical Plan to participate in the Retiree Dental Plan. I must continue to participate in the Retiree Dental Plan and I agree to pay the applicable monthly premium when due through the enrollment period. 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 Medical.

☐ I decline to participate in the Benefit Fund Retiree Dental Plan at this time. ***If you do not enroll in the Benefit Fund Retiree Dental Plan, you will not be able to enroll in the Dental Plan until the third Open Enrollment after you decline coverage.***

Premium Payment Options

☐ **Automatic Deduction From Pension Benefit.** I authorize the Southern California United Food & Commercial Workers Unions and Food Employers Joint Pension Trust Fund to take the applicable deductions for the coverage(s) elected above from my Pension Benefit, and to pay that amount directly to the Benefit Fund. ***If at any time your Pension Benefit is not adequate to cover the cost of the coverage elected, you will automatically be placed under the Direct Payment method.***

☐ **Direct Payment.** I am not receiving a Pension Benefit, or my Pension Benefit is not adequate to cover the cost of the monthly payments, or I wish to make payments directly to the Benefit Fund.

(The Fund Office does not accept recurring electronic transfers from checking or savings accounts, but does accept non-recurring [single transaction] payment by debit card, Mastercard, or Visa credit card. Payments may be made in person or over the phone.)

*Signature*______________________________ *Date*____________________

IMPORTANT: Failure to make required payments timely will result in loss of coverage.

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