TWIN CITIES BAKERY WORKERS HEALTH AND WELFARE FUND

Phone: 651-686-0656 Fax: 651-686-0513

FAMILY STATUS SUMMARY – Enrollment Card

The information on this form is required in order to process your medical claims.

In addition, you are required to inform the Fund office of any changes in your family status due to births, deaths, marriage or divorce, change of name or address, health coverage supplied to your spouse or dependents or due to a job change for any member of your family. Please refer to your Summary Plan Description Booklet for details regarding your Plan benefits. If you have any questions regarding completion of this form, please call 651-686-0656 and ask for the Enrollment Department.

PARTICIPANT INFORMATION – Be sure to complete the entire form.

Employee's Last Name: _____ First Name: _____ MI:_____

Social Security Number:_____ Gender: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: _____ Date of Birth: _____

Marital Status: ☐ Married ☐ Single Date of Marriage: _____ Previously Married? ☐ Yes ☐ No

Are you required by a Divorce Decree or Court Order to provide health benefits for a former spouse or dependent? ☐ Yes ☐ No (include a copy of this Decree or Order, and be sure to list dependents on dependent section below.)

Employer Name: **Lund Food Holdings, Inc**. Job Title: _____

Date of (Re)Hire: _____

OTHER COVERAGE

Are you ☐, your spouse ☐ or any other dependents ☐ eligible for HEALTH or DENTAL coverage from another Employer or Source? (Use another sheet of paper to list additional information.)

Spouse's Employer: _____ Other Source _____

Effective Date:_____ Phone #(s):_____

Spouse's **Health** Coverage: ☐ Single ☐ Family Carrier:_____ Policy/Group#: _____

Spouse's **Dental** Coverage: ☐ Single ☐ Family Carrier:_____ Policy/Group#: _____

DEPENDENT INFORMATION

Include last names or addresses if different from your own, and list any additional dependents or addresses on another sheet.

Spouse First Name	MI	Last Name	Birthdate	Gender	SSN

Dependent First Name	MI	Last Name	Birthdate	Gender	SSN

* **LIFE INSURANCE BENEFICIARY (MUST be completed)**

* Name: _____ Relationship: _____

I certify this information is true and correct to the best of my knowledge. I hereby authorize any insurance company, employer, hospital or physician to release all information with respect to myself or any of my dependents that may have a bearing on the benefits payable under this or any other plan providing benefits or service.

_____ _____

Employee's Signature Date Signed