ENROLLMENT FORM
UAW Group Health and Welfare Fund
LOCAL 2326
PRINT ALL INFORMATION

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Last Name	*First Name*	*M.I.*	*Social Security Number*
Home Address	*City*	*State*	*Zip*

Home Phone # *Cell #* *E-mail Address*

Date of Birth *Gender* *Marital Status: (Circle One)* *Single* *Married* *Divorced* *Widowed*

DENTAL ELECTION (IF APPLICABLE) CIRCLE ONE: YES or NO

List Below Names of Your Spouse and All Dependent Children (up to age 26)

List Names in Order of Age – Oldest First		*Social Security No.*	Relationship *Spouse*	*Son*	*Daughter*	Date of Birth *Month*	*Day*	*Year*
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							

Beneficiary Designations (If applicable)

I hereby authorize the payment of any death benefits as follows:

Welfare Fund

Primary			***Contingent***		
Name(Last, First, MI)			Name(Last, First, MI)		
Address			Address		
SSN	*DOB*	*Relationship*	*SSN*	*DOB*	*Relationship*

Spousal Consent

If you are married and you wish to name someone other than your spouse as the beneficiary, your spouse must consent to your designation by signing below in the presence of a Notary Public. YOUR BENEFITICIARY DESIGNATION WILL NOT BE VALID UNLESS YOUR SPOUSE'S SIGNATURE IS NOTARIZED. As the lawful spouse of the herein-named participant, I herby certify that I agree with the beneficiary designation(s) made above. I understand that by doing so I am waiving any and all rights to my spouse's death benefits and authorize the Administrator of the Fund to pay any death benefit to the above named beneficiaries).

NOTARY

State of ______________________

County of ______________________

Subscribed and Sworn to before me, this ____ day of ________________, 20____.

____ Signature of Employee:

____ Date:

(Notary Public)

Dear Participant:

Please complete the Fringe Benefit Enrollment Form on the reverse side and return it to our office. This form must be *signed and dated in order to be valid.*

The following documentation is ***required*** for you and your eligible dependent(s).

Married- Please provide a copy of your state issued marriage certificate.

Domestic Partner- Please provide a copy of your state issued domestic partnership (CDP) certificate.

Children – Please provide a copy of each child's state issued birth certificate along with adoption papers if adopted.

Stepchildren - Please provide a copy of each dependent's state issued birth certificate along with applicable documentation (i.e. spouse's divorce decree, court documents)

Divorce – Please provide a copy of your divorce decree.

Legible Copies of Social Security Cards - for yourself and each of your eligible dependent(s).

Under the Affordable Care Act (ACA), all individuals are required to maintain health insurance coverage. is required to provide you with a 1095B form detailing who in your family has received coverage from the Welfare Fund. The IRS requires an exact match on the spelling of each name and Social Security number, as indicated on the Social Security card for you and each of your dependents. If there is any deviation, the IRS will reject the submission of your 1095B information. Failure to provide correct information could result in the IRS accessing penalties when you file your income taxes.

The best way to send documents to our office is by sending us an email through our secure email server. This system can be used to send documents of any type, such as benefit applications and claim forms. In order to use the secure link please visit our website at, www.ieshaffer.com , then click the secure email link listed: mail2.ieshaffer.com/securesend

or mail to:

I E Shaffer & Co
PO Box 1028
Trenton NJ 08628