



**2009/2010 UMass Graduate Employee Organization
Health & Welfare Trust Fund Benefits Authorization Form**

This form is for dental & vision enrollments, as well as wellness reimbursement requests.

PLEASE PRINT & SIGN THIS FORM AND RETURN IT TO THE GEO OFFICE (201 Student Union) IN ORDER TO RECEIVE YOUR BENEFITS. This waiver must accompany your online application. If you don't agree with the terms below, or if you have any questions, you may contact us at the GEO Office 413-545-0705 or by calling the benefits administrator at 413-534-7618. For complete benefit plan descriptions & guidelines go to www.hwtrust.geouaw.org

"I certify that all information submitted to the UAW/UMass Health & Welfare Trust is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership and benefits will be determined by my employer and/or the Trustees of the UAW/UMass Health & Welfare Trust and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the Trust for the purpose of providing benefits.

I understand that by signing below, I'm agreeing to release to the administrative employees and Trustees of the UAW/UMass Health & Welfare Trust, to GEO/UAW Local 2322, and to any and all vendors employed by the Trust for the purpose of providing benefits, information necessary to provide me with, and to verify my eligibility for, any and all benefits offered by the Trust (including but not limited to dental, vision, wellness, EAP and childcare assistance).

Finally, I certify that the following benefits (please mark only one option in each column for dental, vision and wellness) are those that I am applying for in plan year 2009-10":

PLAN OPTIONS (mark one option in each column)

<input type="checkbox"/> Dental Benefits, Individual	<input type="checkbox"/> Vision Benefits, Individual	<input type="checkbox"/> Wellness Reimbursement Benefit (if you expect to apply for reimbursement during 09-10, please check this box)
<input type="checkbox"/> Dental Benefits, Family and "I certify I have made my \$100 payment via check, credit or payroll deduction"	<input type="checkbox"/> Vision Benefits, Individual + 1 person (spouse <u>or</u> child)	
<input type="checkbox"/> Neither of the above plans	<input type="checkbox"/> Vision Benefits, Family	
	<input type="checkbox"/> None of the above	

EMPLOYEE ASSISTANCE PROGRAM

"I understand all eligible graduate employees are automatically enrolled and able to access the Employee Assistance Program benefits provided by the UAW/UMass Health & Welfare Trust."

WELLNESS REIMBURSEMENT OPTION

"I certify that I am attaching here a copy of a valid receipt for membership fees/fees/tuition I have already paid to an institution or program providing fitness or wellness activities to me during the plan year November 1, 2009-October 31, 2010. I understand that the maximum reimbursement for plan year 2009-10 is \$80.00 per year. I understand that the UAW/UMass Health & Welfare Trust Trustees reserve the right to reject requests for reimbursement that fail to meet the reimbursement guidelines."

Amount of receipt submitted: \$ _____

NAME (please print)

SIGNATURE

UMASS STUDENT ID
(must be filled in to be processed)

DATE

(revised Sept 2009)