2009/2010 UAW/UMASS Health & Welfare Trust Paper Application & Authorization Form

ONLY TO BE USED BY THOSE WITH NO ACCESS TO THE ONLINE ENROLLMENT SYSTEM— PAPER APPLICATIONS WILL SLOW THE PROCESSING OF YOUR ENROLLMENT.

Enter enrollment information below (filling out all fields is required)

First Name: ____________________ Last Name: __________________________ Gender: ______

Address 1: ____________________ Address (line 2): ____________________ City: __________________

State: _____ Zip: ___________ Phone: __________________ Email address: __________________________

Social Security #: _______________ UMass Student ID #: ______________ Date of Birth: mm /dd /yyyy

Apply for Delta Dental PPO Plus Premier Plan for plan year 2009-10? (please X the appropriate box below):

☐ Single (free) ☐ Family (enrollee must pay $100 for year with application) ☐ Neither plan

Apply for EyeMed Vision Plan for plan year 2008-09? (please X the appropriate box below):

(all plans are free) ☐ Single ☐ Single+1 other person ☐ Family ☐ None of these plans

PLEASE LIST ANY PLAN DEPENDENTS for the above plans, IF APPLICABLE:

	First Name	Last Name	Date of Birth	Gender
Partner				
Children				

Apply for Wellness Reimbursement for plan year 2009-10? (please X the appropriate box below):

☐ Yes, I have my receipt now Amount of receipt(s) submitted: $___________

☐ Yes, but I will turn in my receipt & form later ☐ No, I am not applying

"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."

Employee Assistance Program for plan year 2009-10: "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."

"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 above 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:"

______________________________ ____________________________ _________________ _____________
NAME (please print) SIGNATURE UMASS STUDENT ID DATE

Please return this form to: GEO, 201 Student Union Building, UMass Amherst 01003 *(revised Aug. 2009)*