unitedag
UNITED AGRICULTURAL BENEFIT TRUST

54 Corporate Park • Irvine, CA 92606-5105

EMPLOYEE ENROLLMENT FORM

Phone: (800) 223-4590 • **Fax**: (949) 892-1352 • **Email:** enrollment@unitedag.org

PLEASE USE INK PEN ONLY. Fill out the form completely to avoid any delays in processing.

◊ Use the UnitedAg Enrollment Change Form to change status or coverage. ◊

UnitedAg Use Only
Date Eff. _____
Initials _____
Date _____

Group Name & Number:

Effective Date:

☐ Medical Plan _____
☐ RX Plan _____
☐ Dental Plan _____
☐ Vision Plan _____
☐ Life Plan _____

1. Enrollment Reason:

☐ New Hire
☐ Rehired/Returning Employee
Date: _____
☐ Status Change
Date: _____
☐ New Group Enrollee (For New Business ONLY)

☐ Open Enrollment
☐ Late Enrollment
Reason:
_____
_____

☐ COBRA
Original Effective Date:
_____
Qualifying event:
_____

2. Employee Information (if enrolling): 20 Character Limit

Date of Hire	Occupation	Date of Birth (Format: MM/DD/YYYY)	Gender ☐ M ☐ F	Social Security # (Write N/A if SSN not available)

Last Name																				
First Name																				M.I.

Address	City	State	Zip Code

Mobile Phone (Required)	Personal E-mail (Required)	Preferred Language (Required) ☐ English ☐ Spanish

3. Dependent Information (if enrolling):

***Please note:** A signed and notarized Declaration of Domestic Partnership for Healthcare is required to enroll a domestic partner.
Dependents over the age of 18 will receive their explanation of benefits (EOB).

Gender (check boxes below)	Last Name (Skip if same as Employee) 20 Character Limit	First Name (20 Character Limit)	Middle Initial	Date of Birth (Format:MM/DD/YYYY)	(Write N/A if SSN not available)	Mobile Phone (required if available)
Circle: Spouse / Domestic Partner ☐ M ☐ F						
Address (if not living with Employee)		Email				Preferred Language ☐ English ☐ Spanish
Child ☐ M ☐ F						
Address (if not living with Employee)		Email				Preferred Language ☐ English ☐ Spanish
Child ☐ M ☐ F						
Address (if not living with Employee)		Email				Preferred Language ☐ English ☐ Spanish
Child ☐ M ☐ F						
Address (if not living with Employee)		Email				Preferred Language ☐ English ☐ Spanish
Child ☐ M ☐ F						
Address (if not living with Employee)		Email				Preferred Language ☐ English ☐ Spanish

4. Group Life Insurance Beneficiary Designation:

I hereby, apply for life insurance benefits and designate the beneficiary named below to receive the proceeds, if any, payable in the event of my death.

Primary Beneficiary	Relationship
Contingent Beneficiary	Relationship

If you are married and your spouse is not the Primary Beneficiary, please obtain spouse's signature indicating consent.

Spouse's Signature _____ Date _____

5. Other Coverage for Enrolling Applicants:

1. Is anyone eligible and covered by Medicare? If yes, who? _____ Yes ☐ No ☐
2. Do you currently have other health coverage? Yes ☐ No ☐
If yes, which carrier? _____
Do your dependents? Yes ☐ No ☐
If yes, which carrier? _____
3. Do you intend to continue other group coverage? Yes ☐ No ☐
Do your dependents? Yes ☐ No ☐

UABT does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, UABT will not require a provider to obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles, co-payments, and out-of-pocket expense applicable to other medical and surgical benefits provided under your UABT plan. If you would like more information on WHCRA benefits, call UABT's Member Service Department at (800) 223-4590.

The above information given to obtain participation in UABT is true and complete to the best of my knowledge and belief. I understand that if any information provided herein proves to be false, UABT reserves the right to deny any claim and revoke all participation in UABT retroactive to the effective date of participation. This statement shall constitute a part of my application for benefits under the Plan Document. I understand that participation in UABT will not become effective unless and until the first payment has been made and UABT approves and accepts this application. I give UnitedAg and its vendors permission to send me emails and text messages with information about my health benefits. Your personal information will not be sold.

Employee Signature:

Date:

CONSENT FORM TO RECEIVE ELECTRONIC DISTRIBUTION OF HEALTH PLAN INFORMATION

54 Corporate Park • Irvine, CA 92606

Phone: 800.223.4590 • **Email:** enrollment@unitedag.org • **Website**: unitedag.org

Statement Regarding Electronic Disclosures of Plan Information

This Consent Form explains electronic document disclosure requirements. Under the Employee Retirement Income Security Act of 1974 (ERISA) and related regulations, you must give your voluntary consent to receive electronic copies of employee benefit communications. ***This Consent Form is to obtain your voluntary consent to receive all ERISA communication documents and mandatory disclosures by electronic delivery instead of paper delivery***. UnitedAg, as the Plan Administrator of the United Agricultural Benefit Trust (UABT or the Plan), intends to provide to you by electronic delivery the following documents:

- Summary Plan Description (SPD) and Summaries of Material Modifications (SMMs);
- Summary Annual Report (SAR);
- Summaries of Benefits and Coverage (SBC);
- Annual Notices relating to Medicare Part D, Children's Health Insurance Program (CHIP) and Women's Health and Cancer Rights Act (WHCRA);
- Health Insurance Marketplace Notices;
- HIPAA certificates of creditable coverage; and
- Any ERISA required documents relating to the Plan upon you or your beneficiary's request.

Electronic Delivery Method to Be Used

ERISA required documents will be posted on the UnitedAg Health Portal at http://webportal.unitedag.org. You will receive an email from UnitedAg notifying you when a document has been posted on the Health Portal.

Accessing Documents on the Health Portal

If you have not created an account on UnitedAg's Health Portal, please do so as soon as possible. Log on to http://webportal.unitedag.org, click on the green button labeled "Register" below "First Time User" to set up your account. Once you are in the Health Portal, click on the green tab labeled "Documents" on the left side of the screen. You can download all the ERISA documents posted under the "Documents" tab. To access documents provided on the Health Portal, you must have (1) internet access with a computer or smartphone (iPhone or android) using a Chrome, Safari or Firefox browser; (2) an email account that allows you to send and receive emails; and (3) a PDF viewer (such as Adobe Reader available for free at https://get.adobe.com/reader) installed on your device. The PDF viewer allows you to open and download the document. To retain a copy of the document, you must (1) print a copy on a printer attached to your device; or (2) save a copy onto your device or flash drive. If you are no longer able to access and retain electronically transmitted documents, you will be furnished with notice and required to provide another Consent Form for receiving documents electronically.

Your Right to a Free Paper Copy

You have a right to request and obtain a paper copy, free of charge, of any ERISA document posted on the Health Portal. Contact UnitedAg Member Services at 800.223.4590 or email at memberservices@unitedag.org to request your free paper copy.

Authorization

I acknowledge that I have read the Statement Regarding Electronic Disclosures of Plan Information. I voluntarily consent to the electronic disclosure of all ERISA required documents listed above. I understand that I will receive copies of these ERISA required documents by accessing the UnitedAg Health Portal. I verify that I have the ability and necessary electronic device(s) to access the UnitedAg Health Portal. I understand I need to create an account on UnitedAg's Health Portal to access these ERISA documents. If my email address changes, I understand that I must notify UnitedAg Group Administration by sending an email to enrollment@unitedag.org. I understand that I can withdraw my consent at any time by sending an email to UnitedAg at enrollment@unitedag.org with "Consent Withdrawn for Electronic Disclosure" in the subject line and my full name, address, and phone number. I understand that, upon request, I have the right to receive free paper copies of all ERISA required documents.

Print Member Name:	**Member ID Number:**
Signature:	**Date:**
Email Address:	

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54 Corporate Park • Irvine, CA 92606-5105

WAIVER OF COVERAGE FORM

54 Corporate Park • Irvine, CA 92606-5105
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◊ Please use the UnitedAg Enrollment Change Form to change status or coverage. ◊

W

UnitedAg Use Only
Date Eff. _____
Initials _____
Date _____

Group Number:	**Company Name:**

Waiver Date:	**1. Waiver Reason** (Please check one):	**2. Waiving Coverage for** (Check all that apply):
☐ Medical Plan _____ ☐ RX Plan _____ ☐ Dental Plan _____ ☐ Vision Plan _____ ☐ Life Plan _____	☐ Have other coverage Name of Carrier:_____ ☐ Covered by Medicare Who? _____ ☐ Cost is too high ☐ Other _____	☐ Myself ☐ Spouse / Domestic Partner ☐ Child(ren)

3. Employee Information (if waiving):

Date of Hire	Occupation	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F	Social Security # (Write "N/A" if SSN not available)
Last Name		First Name		Middle Initial
Address		City	State	Zip Code
Phone		E-mail		

4. Dependent Information (if waiving):

Gender	Last Name (SKIP if same as Employee)	First Name	Middle Initial	Date of Birth (MM/DD/YYYY)	Social Security # (Write "N/A" if SSN not available)	Address (if not living with Employee)
Circle: Spouse / ☐ Domestic Partner ☐ ☐ M ☐ F						
Child ☐ M ☐ F						
Child ☐ M ☐ F						
Child ☐ M ☐ F						
Child ☐ M ☐ F						
Child ☐ M ☐ F						

5. Employee Signature

If you are declining enrollment in United Agricultural Benefit Trust (UABT) for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in UABT if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in UABT if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under UABT, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

I/We am/are waiving coverage under my employer's health plan through UABT. I/We understand that failure to elect coverage at this time qualifies me/us as a "Late Enrollee" and may result in a 12 month waiting period, when I/we elect to enroll at a later date. I/We may, however qualify as a "Special Late Enrollee (with no waiting period) when I/we seek to enroll at a later date. As a "Special Late Enrollee" I/we would qualify for participation in my employer's health plan without a 12-month waiting period provided if I/we apply for benefits within 31 days of a loss of alternative coverage.

Employee Signature: **Date:**