



# Walgreen Co. and Local 648 Welfare Trust Enrollment/Change Form

Form 603 (3/99)

FOR OFFICE USE ONLY	
Coverage	Effective Date

(Return both copies to address on the reverse side of this document, for your convenience, you may fold, seal and affix postage.)

## Personal Information

Employee Name (Last, First, Middle Initial)			Social Security Number		
Employee Address (Street, City, State, Zip Code)			Work Location Number		
County	Date of Hire	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>	Work Location Phone Number ( )	
			Home Phone Number ( )		

## Medical/Dental Coverage Selection

Plan Selection:

Kaiser Medical with Delta Dental

Health Net Medical with Delta Dental

United Healthcare Medical with Delta Dental

Coverage Selection:

Employee Only

Employee & One Dependent

Employee & Two or More Dependents

## Application Information

If not currently enrolled in a Medical Plan with Walgreens  
Please Check One: Initial Eligibility  Open Enrollment (May 15 - June 15)  Part Time to Full Time Status  Change in Life Status\*

If currently enrolled in a Medical Plan with Walgreens  
Please Check One: Address Change  Adding Dependents\*  Name Change  Dropping Dependents\*  Beneficiary Change  Change Medical Plan\*  Physician Change  Cancel Coverage\*

Current Medical Plan Code: Alpha   Numeric

**NOTE:** You can only make changes to your coverage within 31 days of a change in life status or during the open enrollment period for the plan you are enrolled in.

\* If adding or dropping dependents, or changing or canceling Medical Plans due to a change in Life Status, please indicate reason for change:

EVENT	DATE OF EVENT	EVENT	DATE OF EVENT	EVENT	DATE OF EVENT
Marriage	_____	Ineligible	_____	Adoption	_____
Divorce	_____	Dependent	_____	(Child Placement Agreement from an adoption agency or court documentation required)	_____
Birth	_____	Other:	_____		

## Employee and Dependent Information

List dependents to be covered under the plan: (If you need additional space, please use an additional form and attach it to this form.)  
(NOTE: If currently enrolled and you are adding or dropping dependents, please indicate by checking the appropriate box in the column specified below.)

Check One Below	Relationship	Date of Birth MM/DD/YY	Name Last, First, Middle Initial	Social Security Number	Primary Care Physician or Center	Physician Code
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Employee			<input type="text"/> - <input type="text"/> - <input type="text"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Spouse			<input type="text"/> - <input type="text"/> - <input type="text"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="text"/> - <input type="text"/> - <input type="text"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="text"/> - <input type="text"/> - <input type="text"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="text"/> - <input type="text"/> - <input type="text"/>		
<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="text"/> - <input type="text"/> - <input type="text"/>		

## Other Insurance Information

Does your spouse or dependent have other Group Insurance?  Yes  No If Yes, please complete the following section:

Insurance Carrier Name:	Policy Number:	Effective Date:
Who is covered?	Address:	Phone Number:

## Beneficiary Designation

Membership in this plan provides a life insurance benefit in the event of a covered employee's death with additional protection against accidental death and dismemberment (AD&D). Please designate a beneficiary:

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_

## Authorization

**NOTE: Complete this section if you were hired on or after September 17, 1988.**

I received and read the summary plan description (SPD). I authorize my pay to be reduced by the cost of coverage and I understand the amount of the reduction will be used to pay for coverage. I understand that I may NOT cancel or change my coverage during the plan year, EXCEPT as stated in the SPD, and that it is my responsibility to keep all information current pertaining to this application.

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_