**SPOUSAL COVERAGE VERIFICATON FORM**

**ELECTRICAL WORKERS 292 FRINGE BENEFIT PLANS**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section 1 | Member Name | |  |  | Sex | Date of Birth |  | Last 4 of Social Security # or Healthcare ID # | | |
|  |  |  |  | €M € F |  |  |  |  |  |
| Spouse's Name | |  |  | Sex | Date of Birth |  | Spouse's Social Security # | |  |
|  |  |  |  | €M  € F |  |  |  |  |  |
| Address |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Members Phone # | |  |  | Spouse's Phone # | |  |  | Date of Marriage | |
|  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section 2 | Spouse's Employer Information | | | | | | | | | |
| Is your spouse employed? | |  |  |  |  |  |  |  |  |
| €Yes, but is not enrolled in medical coverage at this time. **(Please complete section 4 and section 6.)** | | | | | | | | |  |
| €Yes and currently has medical coverage through their employer. **(Please complete section 5 and section 6.)** | | | | | | | | | |
| € No or Self Employed **(Please complete section 3 and section 6.)** | | | | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Spouse's Employer Name | |  |  |  | Hire Date |  | Spouse's Employer Phone | |  |
|  |  |  |  |  |  |  |  |  |  |
| Spouse's Employer Address | | |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section 3 | By signing below, I certify that my spouse is not employed | | | | | Notary: Please affix seal here | | | | |
| or is self-employed and is not eligible for other insurance. | | | | |  |  |  |  |  |
| I understand my signature under this portion of the form | | | | |  |  |  |  |  |
| must be notarized with each yearly submission. | | | |  |  |  |  |  |  |
| Member Signature | |  |  |  | Notary Public's Signature | | |  |  |
|  |  |  |  |  |  |  |  |  |  |
| Date |  |  |  |  | Date |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Section 4 | To Be Completed by Spouse's Employer | | | | | | | | | |
| **(If not enrolled in medical coverage)** | | | | | | | | | |
| € Employer does not offer medical coverage for this employee. | | | | |  |  | |  |  |
| This employee is not eligible for medical coverage under the employer's plan due to (i.e. part time status): | | | | | | | | |  |
| Medical Coverage is available to this employee, but premiums are $250.00 or more per month. Any optional or voluntary benefits | | | | | | | | | |
| (like vision, dental or dependent coverage) would not count towards the $250.00 threshold. | | | | | | | |  |  |
| Monthly cost to employee if enrolled: | | | |  |  |  | |  |  |
| The employee has coverage available after his/her waiting period expires. Waiting period expires: | | | | | | | | |  |
| €Employee currently does not have coverage but will enroll during employer’s open enrollment period effective: | | | | | | | | | |
| I hereby certify that the participant's spouse named on this form is an employee of the above-named employer. | | | | | | | | | |
| I further certify that the above check statement is true. | | | | | | | | | |
| Employer Representative | | |  |  |  | | Position |  |  |
|  |  |  |  |  |  | |  |  |  |
| Representative Signature | | |  |  |  | | Date |  |  |
|  |  |  |  |  |  | |  |  |  |

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| Section 5 | Spouse's Other Insurance Information | | | | | | | | | |
| Type of Policy: | |  |  |  |  |  | |  |  |
| Employer Medicaid Medicare Tricare  Active Retiree € Inactive Retiree  COBRA  Veterans Benefits | | | | | | | | | |
| Insurance Name | |  |  |  | Insurance Policy # | | |  |  |
|  |  |  |  |  |  | |  |  |  |
| Insurance Group # | |  | Phone # | |  | | Effective Date | |  |
|  |  |  |  |  |  | |  |  |  |
| Insurance Address | |  |  |  | Monthly Cost  To Employee | |  |  |  |
|  |  |  |  |  |  | |  |  |  |
| Type of Coverage Under Policy | | | Coverage (Check all that apply) | | | |  |  |  |
| €Individual  € Family |  | | €Medical  € Dental Health Reimbursement Account (HRA)  €Vision Health Savings Account (HSA)  € Prescription | | | | | |  |
| If your spouse has Medicare, please complete the following: | | | | |  |  | |  |  |
| Effective Date Part A | |  |  | Cancellation Date | |  | |  |  |
| Effective Date Part B | |  |  | Cancellation Date | |  | |  |  |

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| Section 6 | Certification of True Statement | | | | | | | | |
| I hereby certify that the above statements are true and complete to the best of my knowledge. I understand | | | | | | | | |
| that if I intentionally falsify or fail to give any of the above information on this form, claims may be denied | | | | | | | | |
| and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes | | | | | | | | |
| in the above information within 30 days of the change. Further, I give the Fund permission to contact my | | | | | | | | |
| employer to inquire about any of the information listed on this form. I give any employer listed on this form | | | | | | | | |
| permission to release any information regarding my employment and insurance benefits with said employer | | | | | | | | |
| to the Fund; and I release the Fund and any said employer from any liability associated with requesting | | | | | | | | |
| and/or providing said information as set out above. This form must be signed by participant and spouse. | | | | | | | | |
| Member's Signature | |  |  |  |  | Date |  |  |
|  |  |  |  |  |  |  |  |  |
| Spouse's Signature | |  |  |  |  | Date |  |  |
|  |  |  |  |  |  |  |  |  |

Revised 10/8/19