**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 |
|   |   |   |   |   |   |   |   |   |   |

|  |  |
| --- | --- |
| 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