

SPOUSAL COVERAGE VERIFICATION FORM

I.B.E.W. Health Care Plan
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Section 1

Member Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Last 4 of Social Security #
Spouse's Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Spouse's Social Security #
Address			
Members Phone #	Spouse's Phone #		Date of Marriage

Section 2

Spouse's Employer Information		
Is your spouse employed? <input type="checkbox"/> Yes, but is not enrolled in medical coverage at this time. (Please complete section 4 and section 6.) <input type="checkbox"/> Yes, and currently has medical coverage through their employer. (Please complete section 5 and section 6.) <input type="checkbox"/> 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		

Section 3

By signing below, I certify that my spouse is not employed 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.	Notary: Please affix seal here
Member Signature	Notary Public's Signature
Date	Date

Section 4

To Be Completed by Spouse's Employer (If not enrolled in medical coverage)	
<input type="checkbox"/> Employer does not offer medical coverage for this employee.	
<input type="checkbox"/> This employee is not eligible for medical coverage under the employer's plan due to (i.e. part time status):	
<input type="checkbox"/> 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:	
<input type="checkbox"/> The employee has coverage available after his/her waiting period expires. Waiting period expires:	
<input type="checkbox"/> 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

Spouse's Other Insurance Information

Section 5

Type of Policy: <input type="checkbox"/> Employer <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> Active Retiree <input type="checkbox"/> Inactive Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Veterans Benefits		
Insurance Name		Insurance Policy #
Insurance Group #	Phone #	Effective Date
Insurance Address		Monthly Cost of Medical Coverage to Employee
Type of Coverage Under Policy <input type="checkbox"/> Individual <input type="checkbox"/> Family	Coverage (Check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Health Reimbursement Account (HRA) <input type="checkbox"/> Vision <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Prescription	
If your spouse has Medicare, please complete the following:		
Effective Date Part A		Cancellation Date
Effective Date Part B		Cancellation Date

Section 6

Certification of True Statement

<p>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.</p>	
Member's Signature	Date
Spouse's Signature	Date