SPOUSAL COVERAGE VERIFICATON FORM

I.B.E.W. 292 Health Care Plan
6900 Wedgwood Road North, Suite 425, Maple Grove, MN 55311
Phone (763) 493-8830 • (800) 368-9045 • Fax (763) 416-6196
www.ibew292benefits.org • enrollment@ibew292benefits.org

Section 1

Member Name	Sex ☐M ☐F	Date of Birth	Last 4 of Social Security #
Spouse's Name	Sex ☐M ☐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?

☐ 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		

Section 3

By signing below, I certify that my spouse is not employed or is self-employed and is not eligible for other insurance.	
Member Signature	Date

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

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

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