# Spousal Coverage Verification Form

section 1

| Pronouns | Participant's Name | Participant's Preferred First Name | Social Security # or Policy Holder's ID |
|---|---|---|---|
| | | | |

| Date of Birth | Gender at Birth: ○ Female ○ Male Gender Identity: ○ Female ○ Male ○ Other_____ **If you have legal documentation regarding gender identity, please submit with this form.** |
|---|---|

| Pronouns | Spouse's Name | Spouses's Preferred First Name | Social Security # or Policy Holder's ID |
|---|---|---|---|
| | | | |

| Date of Birth | Gender at Birth: ○ Female ○ Male Gender Identity: ○ Female ○ Male ○ Other_____ **If you have legal documentation regarding gender identity, please submit with this form.** |
|---|---|

Address

| Participant's Phone # | Spouse's Phone # | Date of Marriage |
|---|---|---|
| | | |

## Spouse's Employment Information

section 2

**Is your spouse employed?**

○ Yes, but is not enrolled in medical coverage at this time. (Please complete this section (2) and section 4 and section 6.)

○ Yes and currently has medical coverage through employer. (Please complete this section (2) and section 5 and section 6.)

○ No or Self Employed. (Please complete section 3 and section 6.)

| Spouse's Employer Name | Hire Date | Current Position | 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** |
|---|---|
| Participant's Signature | Notary Public's Signature or visit the Welfare Fund for an employee's signature |
| Date | Date |

## To Be Completed by Spouse's Employer

(If not enrolled in medical coverage)

section 4

○ Employer does not offer medical coverage to this individual.

○ This individual is not eligible for medical coverage under this employer plan due to (i.e. part time status):

○ Medical coverage is available to this employee, but premiums are 100% employee paid and the employee does not receive any type of credit to be used toward the cost of medical and prescription drug coverage.

○ Medical coverage is available to this employee. This employee declined coverage and did not enroll.

**Employee was last eligible to enroll on:**_____. **The earliest date employee can enroll for medical coverage is**:_____.

○ The employee has coverage available after his/her waiting period expires. Waiting period expires:

○ This individual is not eligible for medical coverage until annual open enrollment.

Open enrollment begins: _____ Effective date of insurance coverage: _____

Name and phone number of insurance carrier: _____.

**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 checked statement is true.**

| Employer Representatives Name | Position |
|---|---|
| | |
| Employer Representatives Signature | Date |
| | |

Continue

# Spousal Coverage Verification Form

Section 5

## Spouse's Other Insurance Information

Type of policy:

○ Employer ○ Medicaid ○ Medicare ○ Tricare ○ Active Retiree ○ Inactive Retiree ○ Cobra Veterans Benefits

| Other Insurance Name | | Other Insurance Policy # |
|---|---|---|
| Other Insurance Group # | Other Insurance Phone # | Effective Date |
| Other Insurance Address | | |

| Type of Coverage Under Policy | Coverage's (please check all that apply) |
|---|---|
| ○ Individual Family ○ Family | ○ Medical ○ Hospital ○ Dental ○ Vision ○ Mental Health/Substance Abuse ○ Prescription Drugs |

If your spouse has Medicare, please complete the following:

Effective Date Part A _____ Cancellation Date Part A _____

Effective Date Part B _____ Cancellation Date Part B _____

section 6

## Certification of True Statement

I certify that all of the information contained on this form is accur ate and complete to the best ofmy knowledge. If my spouse's employment situation changes, or they no longer qualify as a dependent under UFCW Local 655 Welfare Fund, I will contact the Fund Office within 30 days. I hereby authorize my employer to release information regarding my employer's health insurance plan and my eligibility for coverage under that plan to the Fund. I understand this authorization remains in effect as long as I am eligible for benefits under the Fund. I understand the purpose and scope of this authorization is to allow the Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

| Participant's Signature | Date |
|---|---|
| Spouse's Signature | Date |

## Special Rules for Coverage of Your Spouse

- **If your spouse is employed you will need to complete and submit this Spousal Coverage Verification Form. This form is required each year in order to maintain coverage for your Spouse.**

- **If your spouse has other medical or prescription drug coverage available through their employer, and your spouse's employer subsidizes a portion of the cost, your spouse must elect coverage under that employer's plan. If your spouse does not elect coverage under their employer's Plan, your spouse will not be covered under the Welfare Fund Plan.**

### Please submit this form via one of the following:

*(preferred)* **1** Log in to your participant portal at **www.655hw.org** or scan the **QR code** below for quick access. Then, use the **"FORM UPLOAD"** feature to directly send your form to your welfare fund file.

**2** Fax: 314.966.9848

**3** Mail to:
**UFCW LOCAL 655 WELFARE FUND**
**300 Weidman Road, Suite A**
**allwin, Missouri 63011**