

# SPOUSAL COVERAGE VERIFICATION FORM

## WELFARE FUND BENEFITS OFFICE • UFCW LOCAL 655

13537 Barrett Parkway Drive, Suite 100 – Manchester, Missouri 63021 – (314) 835-2700 (in St. Louis) or (866) 565-2700 (outside St. Louis)

### Participant Information

Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

### Marital Status:

- Single: Sign *Certification of True Statement* below.
- Widowed: Sign *Certification* below. Date of spouse's death \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Married: Date of Marriage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Complete following question).
- Divorced: Date of Divorce: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Legally Separated: Date of Separation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Spouse Information

Name: \_\_\_\_\_ Gender:  Male  Female  
Last Name First Name Middle Initial

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year

### Certification of True Statement

I certify that all of the information contained on this form is accurate and complete to the best of my knowledge.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Is your spouse employed?

- Yes (complete reverse side of form)
- No (complete bottom of form)
- Self-employed (complete bottom of form)

### Certification That Spouse Is Not Employed or Is Self-employed

By signing below, I certify that my spouse is not employed or is self-employed and therefore not eligible for other coverage through an employer. I understand my signature under this portion of the form must be notarized.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notary Public's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

[Notary: Please affix seal to the upper right portion of this form.]

**To be completed by Spouse's employer**  
**Employed - Coverage is not elected, available or subsidized**

Employer Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employee's Name \_\_\_\_\_ Employee's Hire Date: \_\_\_\_\_ Employee's current position: \_\_\_\_\_

I hereby certify that the participant's spouse named on this form is an employee of the above named employer. I further certify that (check appropriate box):

- 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. 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: \_\_\_\_\_

Employer Representatives Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Other Insurance Coverage Information**  
**[To be completed by Spouse]**

Employer Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Hire Date: \_\_\_\_\_ Current position: \_\_\_\_\_

Name of Other Insurance: \_\_\_\_\_

Address of Other Insurance: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number of Other Insurance: (\_\_\_\_) \_\_\_\_\_ Policy Number (as it appears on insurance card): \_\_\_\_\_

Group number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

- |                                 |                                     |                                        |                                   |                                 |                                 |                                             |                                                           |
|---------------------------------|-------------------------------------|----------------------------------------|-----------------------------------|---------------------------------|---------------------------------|---------------------------------------------|-----------------------------------------------------------|
| <u>Type of Coverage</u>         |                                     | <u>Coverage (Check all that apply)</u> |                                   |                                 |                                 |                                             |                                                           |
| <input type="checkbox"/> Family | <input type="checkbox"/> Individual | <input type="checkbox"/> Medical       | <input type="checkbox"/> Hospital | <input type="checkbox"/> Dental | <input type="checkbox"/> Vision | <input type="checkbox"/> Prescription Drugs | <input type="checkbox"/> Mental Nervous / Substance Abuse |

If provided by a Union, please list the name and local number: \_\_\_\_\_

I hereby certify all of the information in this section is accurate and complete to the best of my knowledge. 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.

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_