

SPOUSAL COVERAGE VERIFICATION FORM

UNITED FOOD & COMMERCIAL WORKERS LOCAL 655 WELFARE FUND

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

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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

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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: ____ / ____ / ____

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Spouse Information

Name: _____ Gender: • Male • Female
Last Name First Name Middle Initial

Social Security Number: _____ Birth Date: ____ / ____ / ____
Month Day Year

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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: _____

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Is your spouse employed?

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

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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.]

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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: _____

Type of Coverage

Coverage (Check all that apply)

- Family • Individual • Medical • Hospital • Dental • Vision • Prescription Drugs • 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: _____