2022 SPOUSE EMPLOYMENT INFORMATION FORM

Complete and return to Fund Office. You are required to keep the Fund Office advised if any of the following information changes. BE SURE THAT YOU AND YOUR SPOUSE SIGN THE FORM ON THE BACK.

Participant's Name_____

Health Card Enrollee ID Number_____

Are you currently married? ☐ Yes ☐ No If you are not married, no further information is required. Please sign and date this Form below and return the Form to the Fund Office.
If you are married, is your spouse on your policy? ☐ Yes ☐ No If your spouse is not on your policy, no further information is required. Please sign and date this Form below and return Form to the Fund Office.

If married, please answer the following questions about your spouse's employment

1. Name of Spouse _____
2. Spouse's employment status: ☐ Not-employed ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired
3. Name and address of spouse's employer: _____

   _____ Hire Date: _____
4. Telephone number of spouse's employer: _____
5. Does your spouse's employer offer a health plan? ☐ Yes ☐ No

Answer the remaining questions only if you answered "yes" to No. 5

6. Is your spouse eligible to enroll in the employer's health plan? ☐ Yes ☐ No
7. Is your spouse enrolled in the employer's plan? ☐ No ☐ Yes, single coverage ☐ Yes, family coverage

If your spouse's employer offers health coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead. The letter should be addressed to the Michiana Area Electrical Workers Health & Welfare Fund and should state that your spouse is not eligible for the employer's health plan and the reason for his or her ineligibility (for example, because your spouse works part-time).

8. Give name and address of insurance company: _____

   _____

   Group No._____ Individual ID No._____ Effective Date _____

   Type of coverage (check all that apply): ☐ Medical ☐ Rx ☐ Dental ☐ Vision

   Please include a copy of the front and back of your spouse's insurance identification card.
9. If spouse is NOT enrolled, when will your spouse be eligible to enroll in that plan? _____

If your spouse declines to elect available coverage, the Michiana Area Electrical Workers Health and Welfare Fund will NOT pay any benefits for your spouse. This rule may be waived for a newly eligible participant whose spouse was offered but declined the employer's plan. You must submit a letter from the employer on company letterhead verifying this information The letter should be addressed to the Michiana Area Electrical Workers Health and Welfare Fund and should state when and under what circumstances your spouse will have another opportunity to enroll. The Michiana Area Electrical Workers Health and Welfare Fund will waive non-payment rule only until the other plan's next available enrollment date.

6525 Centurion Drive • Lansing, MI 48917-9275
(517) 321-7502 • (877) 244-9473 Toll Free
FAX (517) 321-7508
www.ibew153benefits.org

HARDSHIP EXEMPTION

The Fund's non-payment rule will not apply if your spouse (1) has annual gross earnings less than $20,000, **OR** (2) has annual gross wages greater than or equal to $20,000 but less than $30,000; AND must pay more than $150 per month toward the cost of the least expensive health plan offered by his or her employer. You are responsible for demonstrating your spouse's entitlement to a hardship exemption by submitting a letter from the employer on company letterhead attesting to wages and cost of coverage. The Fund Office will determine whether a spouse with variable wages qualifies for the hardship exemption by looking at the spouse's average wages over the past twelve (12) months.

IMPORTANT

YOU MUST SIGN THE FORM WHERE INDICATED BELOW

I affirm that the information given above is true and correct to the best of my ability and I understand that if I have given false information or made any material misrepresentations in response to the questions in this Form, it could result in a loss of coverage to my spouse and myself and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my responsibility to notify the Fund Office if any of the above information changes.***

Signature of PARTICIPANT/RETIREE **Member ID or Social Security #** **Date**

IMPORTANT

YOUR SPOUSE MUST SIGN THE AUTHORIZATION BELOW

THIS ENTIRE FORM AND THE SIGNED AUTHORIZATION MUST BE RETURNED TO THE MICHIANA AREA ELECTRICAL WORKERS HEALTH & WELFARE FUND OFFICE

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan to the Michiana Area Electrical Workers Health & Welfare Fund. I understand that this authorization shall remain in effect as long as I am eligible for benefits under the Michiana Area Electrical Workers Health and Welfare Fund. I understand that the purpose and scope of this authorization is to allow the Michiana Area Electrical Workers Health and Welfare Fund to verify with my employer whether I am eligible to obtain coverage under my employer's plan. I further affirm that the information given above is true and correct to the best of my ability and I understand that if I have given false information or made any material misrepresentations in response to the questions in this form, it could result in a loss of coverage to my spouse and myself, and could also result in penalties and fines and possibly prosecution. ***I also understand that it is my spouse's responsibility to notify the Fund Office if any of the information on this Form changes.***

Signature of Spouse **Social Security #** **Date**

Telephone number **Secondary telephone number**

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