Spousal Eligibility Affidavit

Members enrolling their spouse in the Toledo Electrical Welfare Fund must complete and return this form on a yearly basis before December 1st. If this form is not completed and returned, your spouse may not be eligible for coverage. If your spouse is eligible for medical and prescription drug insurance through their employer at a cost of $120 or less per month, they must elect that insurance as primary. This cost threshold applies ONLY to medical and prescription drug coverage (not dental, vision, life etc.). Failure to do so may result in the termination of their coverage through TEWF.

SECTION I: SPOUSE TO COMPLETE

Name of Spouse: _____

1. Are you employed? **Yes** **No**

If you answered YES to this question ⬆ your employer must complete Section II of this form

2. Are you eligible for ANY group medical / prescription drug coverage? **Yes** **No**
   (Such as Employer Sponsored, COBRA, Early Retiree)
3. Are you currently enrolled in any other medical plan (Such as Tricare, Medicaid or Medicare) **Yes** **No**
4. If you answered YES to questions 2 or 3, please indicate what plan and *attach a copy of the front and back of the card associated with your policy:*

_____

SECTION II: SPOUSE'S EMPLOYER TO COMPLETE

Name of Employer: _____

1. Is the above employee eligible for medical and prescription coverage through your company's sponsored group health plan? **Yes** **No**
2. Is the employee's cost for the least expensive option for employee-only medical and prescription coverage $120 or less per month? **Yes** **No**

REQUIRED DOCUMENTS: Please include a copy of the enrollment form, benefits summary or other document showing the health plan options and employee's share of the premium for medical/prescription coverage option(s) with this affidavit. The Toledo Electrical Welfare Fund requires this documentation as a condition for spousal eligibility.

Employer Signature: _____ Date: _____

Printed Name/Title: _____ Phone: _____

SECTION III: LOCAL 8 MEMBER TO COMPLETE

Participant (Local 8 Member) Name: _____

Participant (Local 8 Member) UID or Last 4 of SSN: _____

I swear that the above information is true, correct and complete, to the best of my knowledge and belief. I understand that it is my responsibility to inform Toledo Electrical Welfare Fund of any change in my spouse's insurance coverage or eligibility status.

Participant (Local 8 Member) Signature: _____ Date: _____

Please return to: TEWF, PO BOX 60408, ROSSFORD, OH 43460 | fax: 419-666-5410 | e-mail: enrollment@electricalfunds.org