# 2024 Spousal Eligibility Affidavit

**Spouses who wish to be enrolled in the Toledo Electrical Welfare Fund must complete and return this form on a yearly basis before each December 1st. If this form is not completed and returned, you will not be eligible for coverage.**

**If a spouse is eligible for medical and prescription drug insurance through their employer at a cost of $120 or less per month, they must enroll in that insurance coverage. This cost threshold applies ONLY to medical and prescription drug coverage (not dental, vision, life etc.). Failure to do so will 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 (Such as Employer Sponsored, COBRA, Early Retiree)? **Yes** **No**

3. Are you currently enrolled in any government-sponsored medical plan (Such as TRICARE, Medicaid or Medicare)? **Yes** **No**

4. If you answered YES to question 2 or 3, please indicate the plan (s) and *attach a copy of the front and back of the card associated with your policy:*

   Carrier: _____ **Original** Effective Date: _____

**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 health plan options showing the employee's share of the premium for medical/prescription coverage option(s) AND the withholding frequency (e.g. weekly, biweekly, monthly) 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: SPOUSE TO COMPLETE**

**Participant (Local 8 Member) Name:** _____

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

As evidenced by my signature below, 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 employment, my insurance coverage, or my eligibility for such coverage.

Spouse's Signature: _____ Date: _____

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