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.

Name of Spouse: 1. Are you employed? 2. Do you currently have employer-sponsored coverage for yourself for at least Medical/ Prescription drug coverage? If you are employed and do not participate in employer-sponsored coverage your employer must complete Section II of this form If you are employed and answered YES to both #1 and #2 your employer does not have to complete Section II of this form If you are employed and answered YES to both #1 and #2 your employer does not have to complete Section II of this form (continue to question 3) If you are NOT employed continue to question 3 3. Are you eligible for ANY group medical / prescription drug coverage through your current or previous employer (including COBRA or Retiree coverage)? Yes No 4. Are you currently enrolled in any government-sponsored medical plan (i.e. TRICARE, Medicaid or Medicare)? If you answered YES to questions 3 or 4, please indicate the plan(s) and attach a copy of the front and back of the ID card(s) associated with the coverage(s): Carrier: Original Effective Date: Type of Coverage (Circle all that Apply): Medical Dental RX Vision Type of Coverage (Circle One) SINGLE FAMILY (List Covered Dependents): SECTION II: SPOUSE'S EMPLOYER TO COMPLETE Name of Employee's cost for the least expensive option for employee-only medical and prescription coverage S120 or less per month? (THIS INCLUDES ALL PLAN OPTIONS, INCLUDING HIGH-DEDUCTIBLE PLANS) REQUIRED DOCUMENTS: Please include a copy of all the health plan options available showing the employee's share of the premium for medical/prescription coverage option(s) AND the withholding frequency (e.g. weekly, blweekly, semi-monthy) with this affidavit. The Toledo Electrical Welfare Fund requires this documentation as a condition for spousal eligibility. Employer Signature: Participant (Local 8 Member) Name: UID or Last 4 of SSN: As evidenced by my signature below, Iswear that the above information is true, correct, and complete, to the best of my knowledge and belief. Lunderstand	SECTION I: SPOUSE TO COMPLETE				
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Participant (Local 8 Member) Name:		Employer Signature: Date:			
Participant (Local 8 Member) Name:		Printed Name/Title: Phone:			
Participant (Local 8 Member) Name:	SECTIO	N III: <u>SPOUSE</u> TO COMPLETE			
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, within 30 days of the change. Failure to do so may result in my loss of eligibility under TEWF.					
employment, my insurance coverage, or my eligibility for such coverage, within 30 days of the change. Failure to do so may result in my loss of eligibility under TEWF.					
Spouse's Signature: Date:		employment, my insurance coverage, or my eligibility for such coverage, within 30 days of the change. Failure to do so may			
		Spouse's Signature: Date:			

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