Spousal Eligibility Affidavit

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.

Spouses who wish to be enrolled 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, you will not be eligible for coverage.

SECTION I: SPOUSE TO COMPLETE

Name of Spouse: _____

1. Are you employed? **Yes** **No**
2. Do you currently have employer-sponsored coverage for yourself for at least Medical/ Prescription drug coverage? **Yes** **No**

- **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 (continue to questions 3, 4 and 5)**
- **If you are NOT employed continue to questions 3, 4 and 5**

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)? **Yes** **No**
5. 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

☐ CHECK THIS BOX IF YOU ARE SELF-EMPLOYED AND SIGN SECTION II

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? (THIS INCLUDES ALL PLAN OPTIONS, INCLUDING HIGH-DEDUCTIBLE PLANS) **Yes** **No**

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, biweekly, semi-monthly) with this affidavit. *The Toledo Electrical Welfare Fund requires this documentation as a condition for spousal eligibility.*

Employer Signature: _____ Date: _____

Printed Name/Title: _____ **Direct** Phone/Email: _____

_____

SECTION III: SPOUSE TO COMPLETE

Participant (Local 8 Member) Name: _____ 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, **within 30 days of the change**. Failure to do so may result in my loss of eligibility under TEWF.

Spouse's Signature: _____ Date: _____

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