

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.

Employee's name _____ Soc. Sec. No. _____

Are you currently married? yes no Name of spouse _____

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

1. Spouse's employment status: not employed full-time part-time self-employed retired
2. Name and address of spouse's employer: _____

3. Telephone number of spouse's employer: _____
4. Does your spouse's employer offer a health plan? yes no

Answer the remaining questions only if you answered 'yes' to No. 4.

5. Is your spouse eligible to enroll in the employer's health plan? yes no
6. 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 Local No. 701 Welfare Plan 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).

7. Give name and address of insurance company/plan _____

Group ID No. _____ Individual ID No. _____

Type of coverage (check all that apply): medical Rx dental vision

8. 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 Local 701 Plan will pay benefits as if your spouse had elected the other plan and as if the other plan paid 80% of the allowable charges. This means that the Local 701 Plan will ONLY PAY 20% of your spouse's allowable charges. 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. The letter should be addressed to the Local No. 701 Welfare Plan and should state when and under what circumstances your spouse will have another opportunity to enroll. The Local 701 Plan will waive the 20% rule only until the other plan's next available enrollment date.

HARDSHIP EXEMPTION

The 20% Plan 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 \$100 per month toward the cost of the least expensive health plan offered by his or her employer. You are responsible for demonstrating your 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 12 months.

****IMPORTANT****

YOU MUST SIGN THE FORM WHERE INDICATED BELOW.

EMPLOYEE/RETIREE'S SIGNATURE

I affirm that the information given above are true and correct to the best of my ability and I understand that if I have given false information 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 me, and could result in penalties and fines and possibly prosecution.

Signature of **EMPLOYEE/RETIREE**

Social Security No.
or Individual ID

Date

****IMPORTANT****

YOUR SPOUSE MUST SIGN THE AUTHORIZATION FORM BELOW.

**THIS ENTIRE FORM AND THE SIGNED AUTHORIZATION MUST BE RETURNED TO THE
I.B.E.W. LOCAL 701 FUND OFFICE**

SPOUSE'S AUTHORIZATION

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan to the I.B.E.W. Local No. 701 Welfare Plan. I understand this authorization shall remain in effect as long as I am eligible for benefits under the I.B.E.W. Local No. 701 Welfare Plan. I understand that the purpose and scope of this authorization is to allow the I.B.E.W. Local No. 701 Welfare Plan to verify with my employer whether I am eligible to obtain coverage under my employer's health plan. **I further affirm that the information given above are 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 me, and could result in penalties and fines and possibly prosecution.**

Signature of **SPOUSE**

Social Security No.
or Individual ID

Date