2017 Mandatory Annual Working Spouse Coverage Verification Form

Member Name:	Member ID#:	Spouse Name:

SPOUSE: Please Select EITHER SECTION I OR SECTION II OR SECTION III below that best applies to your situation and complete that section.
BOTH MEMBER AND SPOUSE MUST SIGN BELOW.

SECTION I:

____I have group health coverage other than Northeast Carpenters Health Fund (Fill in your coverage information below)

Insurance Company or Plan Name: Attach copy of both sides of Medical Card _____
Insurance Address: _____
Insurance Company/Plan Phone Number: _____
Original Effective Date: _____ Policy/ID#: _____ Name of Employer: _____
Employer's Address: _____

Coverage Includes:

____Medical & Prescription Drug..... ____ Employee Only ____ Family (Please list) _____
____Vision ..... ____ Employee Only ____ Family (Please list) _____
____Dental ..... ____ Employee Only ____Family (Please list) _____

Type: ____ PPO/POS ____ Supplemental ____ HMO ____ Other

Is this Retiree Coverage: ____Yes ____ No

Do you have Medicare Coverage: _____ Yes _____ No If Yes, please provide your Medicare Effective Date: _____

Please attach a copy of your Medicare Card.

SECTION II: Please check the correct boxes below to explain why you do not have coverage:

____ I am not employed
If health coverage terminated within the last year, please indicate the date your coverage ended: _____
(If so, please submit a copy of your Certificate of Creditable Coverage or your Termination Letter.)

____ I am Self-Employed - Name and Type of Business _____

SECTION III:

_____ I am employed, but do not have coverage in my employer's health plan for the reason indicated below. Position _____

_____ I will be eligible for coverage after Open Enrollment. Coverage will Begin on: _____
_____ I am an employee currently in a "Waiting Period. Coverage will Begin on: _____
_____ I am employed 30 hours or less per week.
_____ My employer offers health coverage but does not contribute toward the premium cost, you must submit proof showing your employer does not contribute.
____ My employer does not offer health coverage. Please explain: _____
____ Other: Please explain: _____

*****Employer Verification: Must be completed by Employer if Section III is completed*****

Employer Name: _____
I hereby certify the person on this form is an employee of the Employer above and the information supplied by the employee is accurate and complete to the best of my knowledge.

Employer Representative Signature _____ Date _____

Employer Representative (Please Print) _____ Position _____ Phone _____

MEMBER/SPOUSE SIGNATURE AND AUTHORIZATION: BOTH MUST SIGN

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the Northeast Carpenters Health Fund (Fund) to verify the spouse's employment status as needed. If requested by the Fund, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from us or by withholding from our future benefits. Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the Fund.

Member Signature _____ Daytime Phone _____ Date _____

Spouse Signature _____ Daytime Phone _____ Date _____