UNITED FOOD AND COMMERCIAL WORKERS
UNION LOCAL 1995 AND EMPLOYERS HEALTH AND WELFARE FUND

Full Spouse Coverage Form
Online and Telephone Enrollment

OUR RECORDS INDICATE THAT YOU ELECTED TO ENROLL YOUR SPOUSE IN FULL SPOUSE COVERAGE DURING YOUR ONLINE OR TELEPHONIC ENROLLMENT. PLEASE NOTE THAT YOUR SPOUSE WILL NOT BE ENROLLED UNTIL THIS FORM IS COMPLETED AND RETURNED. **FAILURE TO SEND US THE PROPER VERIFICATION WILL RESULT IN YOUR SPOUSE NOT BEING ENROLLED IN FULL SPOUSE COVERAGE BY THE FUND IN FOR 2020 COVERAGE.**

THIS FORM AND ANY APPLICABLE ATTACHMENTS MUST BE RETURNED TO THE FUND OFFICE NO LATER THAN MARCH 1, 2020.

THIS FORM CAN BE RETURNED TO THE ADDRESS ABOVE OR BY FAX AT 770-909-6596.

NAME: _____ **SOCIAL SECURITY #:** _____

PART 1 – ***Check ✓ one of the following options:***

- ☐ I am currently enrolled in Full Spouse Coverage under the Fund. My spouse either remains unemployed or my spouse remains employed with the same employer and still does not qualify for health coverage with that employer.
- ☐ I am currently enrolled in Full Spouse Coverage under the Fund, BUT my spouse is now eligible to enroll (or will become eligible in 2020) for health coverage through his or her employer **OR** my spouse has changed his or her employer. ***Your Spouse must complete Part 2 of the Full Spouse Coverage Form.***
- ☐ I want to add my spouse for the first time. ***Your spouse must complete Part 2 and attach the documents listed in Part 3.***

PART 2 – ***TO BE COMPLETED BY YOUR SPOUSE***

I am (check ✓ one of the following)**:**

- ☐ NOT employed
- ☐ Employed WITHOUT access to medical benefits from my employer
- ☐ Employed WITH access to but not enrolled in medical coverage from my employer
- ☐ Employed WITH access to and ENROLLED in medical coverage from my employer

SPOUSE'S EMPLOYER NAME AND ADDRESS	**SPOUSE'S EMPLOYER TELEPHONE NUMBER**

SPOUSE'S CERTIFICATION

I hereby certify that the information provided is correct. I understand that any false statements may affect my continued eligibility for benefits under the Fund. I authorize the Fund to contact my employer, if applicable, for information related to healthcare coverage information offered by my employer and authorize its use in the application for coverage under UFCW Unions & Employers Health & Welfare Fund - Atlanta.

Spouse Signature: _____ Date: _____

Certification by Notary:
Subscribed and sworn before me on this _____ day of _____, 20_____.

_____
Notary Public

My commission expires: _____

PART 3 – ***Additional Documents (Only Required if you are enrolling your spouse in Full Spouse Coverage for the first time)***

If you want to add your spouse to your Fund coverage for the first time, please complete Part II of the Full Spouse Coverage Form and provide the following:

1. A copy of your marriage license or certificate.
2. If you have been married for more than three years, we also need one form of dated (within 6 months) documentation establishing current marital status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, or front page of your jointly-filed 2018 tax return (with blacked out financial information).

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MUST BE COMPLETED BY SPOUSE'S EMPLOYER IF YOUR SELECTION ABOVE INDICATES "EMPLOYED WITH ACCESS TO MEDICAL COVERAGE"

Name of Employee: _____

Employee's Date of Hire: _____

Does your Company offer an Affordable Care Act (ACA) complaint health plan? Yes ☐ No ☐

If yes: IS THE PERSON NAMED ABOVE AS Spouse eligible for such health plan? Yes ☐ No ☐
(Please note that "eligible" means that coverage has been offered and does not require that the Spouse has elected to enroll in such coverage.)

Is this person named above as Spouse enrolled in such medical coverage? Yes ☐ No ☐

If your company does offer an ACA complaint health plan, but the Spouse is not eligible for such coverage, please provide a brief description of why he/she is not eligible (i.e., waiting period, works in ineligible job position or status).

If the reason is due to a waiting period, please provide date it will be available: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Authorized Employee Signature: _____ Date: _____

Printed Name: _____ Title: _____

Form Updated 02/04/2020