SPOUSE EMPLOYMENT VERIFICATION FORM

Effective February 2015, if employer provided coverage is newly elected or is continued from the previous year for Health Insurance, this Verification Form must be completed. This form must be completed and returned to the Fund Office along with the 2015 Coordination of Benefits form.

Member Name:_____ UBC # or Last Four of SSN: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Please check ONE of the following below

☐ I am not currently employed/have not been employed in the last year

☐ I am currently employed

☐ My Company does offer Health Insurance ☐ My Company does not offer Health Insurance

☐ I am no longer employed; Last day of employment: _____

My Health Coverage was terminated on: _____ **(copy of Termination Letter MUST be attached)**

☐ I am self-employed. (Please complete and sign the bottom portion of this form)

Section below must be completed and signed by Employer if copies of Employer sponsored insurance cards are not provided

Employee Name: _____

Is Health Care Coverage available to the Employee named above? ☐ YES ☐ NO

Is the Employee named above currently enrolled in Health Care Coverage? ☐ YES ☐ NO

If yes, please indicate which benefits the Employee has elected.

Insurance Company: _____ Policy Number: _____

Type: ☐ PPO ☐ HMO ☐ P.O.S ☐ HSA ☐ High Deductible Health Plan ☐ Other: _____

Covered Benefits: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If **no**, why is the Employee named above **not** enrolled in Health Coverage?

☐ Waiting Period; When will they be eligible for benefits? _____

☐ Eligible, but is waiting for Open Enrollment. When will Open Enrollment take place? _____

☐ Health Coverage is not offered. Reason: _____

☐ Employee did not elect to enroll in Health Coverage

☐ Other: Please Explain _____

Employer Name: _____

I hereby certify the person stated on this form is an Employee and the information above is accurate and complete to the best of my knowledge

Employer Representative Signature and Name Printed : _____

E-Mail: _____ Phone Number _____

MEMBER/SPOUSE AUTHORIZATION AND SIGNATURES (IN ORDER FOR THIS FORM TO BE COMPLETE 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 Carpenters' Health & Welfare 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 _____ Date _____

Spouse Signature _____ Date _____