Spousal Coverage Program Verification Form

FORM A

Carpenters' Health and Welfare Trust Fund of St. Louis (Plan)
1419 Hampton Avenue, St. Louis, MO 63139

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

Do you have other health coverage? ☐ **Yes** ☐ **No** **If Yes, COMPLETE THIS FORM IN ITS ENTIRETY**

I have no other health coverage *(If no other health coverage, you must complete FORM B)*

A. Member Information

Member Name (Last, First, Middle Initial)	Member ID	Spouse Name

Both Member and Spouse must sign at the bottom of this form. Refer to *Guidelines* on page 2 of this document (prior page) for more information.

B. Medicare Information - Completion Required

Are you covered under Medicare?	If you have Medicare, is your coverage due to End Stage Renal Disease?	Are you still employed?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

You must attach a copy of your Medicare Part A and B cards.

C. Spousal Statement of Other Health Coverage *(check all that apply)*

I have other health coverage through: ☐ 1. My Employer ☐ 2. My Parent ☐ 3. Retiree Coverage

☐ 4. A High Deductible Health Plan* ☐ 5. A Health Savings Account (HSA)* *Spouses cannot have both an HSA plan and Carpenters' Plan.*

**Note: When available, a spouse should enroll in the HDHP but decline the HSA portion to have secondary coverage under the Carpenters' Plan – see Guidelines.*

My health coverage is through: **Insurance Plan Name**

Insurance Plan ID:	Insurance Plan Phone #:	Coverage Effective Date:

My Coverage Includes:			
	☐ Medical & Prescription Drug	☐ Employee Only	☐ Family *(List Names)*
	☐ Vision	☐ Employee Only	☐ Family *(List Names)*
	☐ Dental	☐ Employee Only	☐ Family *(List Names)*
	☐ Health Reimbursement Account (HRA)	☐ Employee Only	☐ Family *(List Names)*

Employer Coverage Only: Verification MUST be completed for Section C to be considered VALID if coverage is through your employer.

As the Employer, I hereby certify that the person (spouse) named on this form is an employee of the below named employer and the information supplied by the employee is accurate and complete to the best of my knowledge.

Do you offer multiple coverage options? ☐ **Yes** ☐ **No**

Employer Name	Employer Representative Signature	Date

Employer Representative Name (Please Print)	Employer Representative Title	Phone

D. Spousal "Opt-Out" of Carpenters' Plan

☐ By selecting this box, I decline any spousal coverage in the Carpenters' Plan.

Best Contact Phone Number:

E. Signatures: Both Member and Spouse signatures required

We hereby declare under penalty of perjury that we are legally married in accordance with the laws of the state in which we reside and the information on this form is correct and complete to the best of our knowledge. We authorize the Plan to verify the spouse employment status as needed. If requested by the Plan, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant documents pertaining to common law marriage in the State of Kansas. We understand that if any incorrect or misleading information results in a loss to the Plan, the Plan 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 Carpenters' Plan.

Member Signature	Spouse Signature	Date

Spousal Coverage Program Verification Form

FORM B

Carpenters' Health and Welfare Trust Fund of St. Louis (Plan)
1419 Hampton Avenue, St. Louis, MO 63139

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

Do you have other health coverage? ☐ **Yes** ☐ **No** **If No, COMPLETE THIS FORM IN ITS ENTIRETY**

I have other health coverage *(If you have other health coverage, you must complete FORM A)*

A. Member Information

Member Name (Last, First, Middle Initial)	Member ID	Spouse Name

Both Member and Spouse must sign at the bottom of this form. Refer to *Guidelines* on page 2 of this document for more information.

B. Medicare Information - Completion Required

Are you covered under Medicare?	If you have Medicare, is your coverage due to End Stage Renal Disease?	Are you still employed?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

You must attach a copy of your Medicare Part A and B cards.

C. Spousal Statement of No Other Health Coverage

☐ 1. I have not been employed in the past 12 months.

☐ 2. I am not employed; date employment ended:_____ *If coverage has termed, a **Certificate of Credible Coverage from your previous insurance carrier is required**.*

☐ 3. I am self-employed (see attached *Guidelines*). Name and Type of Business:

☐ 4. I am employed but do not have coverage in my employer's health plan for the following reason(s). ***Employer Verification is required in this section.***

- ☐ a) I will be eligible for coverage after Open Enrollment. Coverage date will begin on:_____ *Enter new coverage information in **Section B on SIDE A** if known.*
- ☐ b) I am currently in a "Waiting Period." Coverage date will begin on:_____ *Please enter new coverage information in **Section B on SIDE A** if known.*
- ☐ c) I am employed an average of less than 30 hours per week.
- ☐ d) My employer offers health coverage but does not contribute to premium cost.
- ☐ e) My employer does not offer health coverage.
- ☐ f) My employer does not offer a "Qualified Plan." Please attach a letter from your employer describing the type of plan available – see attached *Guidelines*.
- ☐ g) Other. *Attach a letter for review explaining your circumstances.*

☐ 5. I have dental coverage but no medical coverage for reason stated in #4 above. *Please complete Dental Information in **Section C on SIDE A**.*

Employer Verification MUST be completed for Section C to be considered VALID.

As the Employer, I hereby certify that the person (spouse) named on this form is an employee of the below named employer and the information supplied by the employee is accurate and complete to the best of my knowledge.

Do you offer multiple coverage options? ☐ **Yes** ☐ **No**

Employer Name	Employer Representative Signature	Date

Employer Representative Name (Please Print)	Employer Representative Title	Phone

D. Spousal "Opt-Out" of Carpenters' Plan

☐ By selecting this box, I decline any spousal coverage in the Carpenters' Plan.

Best Contact Phone Number:

E. Signatures: Both Member and Spouse signatures required

We hereby declare under penalty of perjury that we are legally married in accordance with the laws of the state in which we reside and the information on this form is correct and complete to the best of our knowledge. We authorize the Plan to verify the spouse employment status as needed. If requested by the Plan, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant documents pertaining to common law marriage in the State of Kansas. We understand that if any incorrect or misleading information results in a loss to the Plan, the Plan 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 Carpenters' Plan.

Member Signature	Spouse Signature	Date

Guidelines for the Spousal Coverage Program

Carpenters' Health and Welfare Trust Fund of St. Louis (Carpenters' Plan)

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

The Spousal Coverage Program went into effect January 1, 2009.

Definitions:	
Self-Employed:	An individual, doing business as a sole-proprietor or partner, who either has no employees or offers no health coverage to employees.
Part-Time Employee:	Part-time is defined by the Carpenters' Plan, for the Spousal Coverage Program, as working an average of less than 30 hours per week.
Qualified Plan:	For purposes of the Spousal Coverage Program, a "Qualified Plan' means an employer-sponsored health plan that (i) offers, at minimum, coverage for hospitalization medically necessary surgery, medical outpatient and physician services; and (ii) is subject to state or federal regulations of the insurer of an insured plan or the employer of a self-insured plan.
Open Enrollment:	The time or times during the year when an employee may normally enroll for coverage in an employer-sponsored health plan.
Waiting Period:	The period following initial employment that must elapse before an employee can commence coverage in an employer-sponsored health plan.
Opt-Out:	Voluntarily choosing to decline (or terminate) any spousal dependent coverage in the Carpenters' Plan.
Exempt:	A member's spouse who is not qualified to enroll in health plan coverage through their own employer, or a member's spouse who is not employed.
Non-Exempt:	A member's spouse who is required to enroll in health plan coverage through their own employer.
Non-Compliant:	A member's spouse who is eligible for health plan coverage through their own employer and chooses not to enroll in their own employer's plan, or a member's spouse who does not properly complete the Verification Form for the Spousal Coverage Program.

Program Requirements:

The program requires a working spouse, who is not considered 'Exempt' under the Carpenters' Plan, to enroll in the health coverage plan offered by their own employer as a condition of receiving benefits from the Carpenters' Plan. The working spouse must enroll for employee-only coverage, if offered. In addition to the basic coverage of a qualified plan, the working spouse must obtain prescription drug coverage, if available, but it is not required to elect vision or dental coverage. If different plan types are offered, the working spouse must elect an HMO, PPO, or POS plan rather than a high-deductible plan of another type. If the only plan available is a high-deductible health plan (HDHP), the working spouse should enroll in the HDHP and decline the HSA portion to remain eligible for dependent spouse coverage in the Carpenters' Plan. A spouse may not establish a new Health Savings Account (HSA), nor receive tax-free contributions to an existing HSA, while covered in both an HDHP and the Carpenters' Plan. (If a working spouse enrolled in an HDHP elects to 'Opt Out' of the Carpenters' Plan, the spouse's rights with respect to an HSA will not be affected.)

Other Insurance:

The working spouse's employee health plan will pay claims as 'Primary' carrier and the Carpenters' Plan will pay 'Secondary.' If a working spouse has coverage in the form of a Health Reimbursement Account, all charges covered by that HRA must be processed prior to submitting to the Carpenter's Plan. The Carpenters' Plan will pay 'Primary' only if a spouse is considered 'Exempt' in the Carpenters' Spousal Coverage Program.

Open Enrollment Period:

A working spouse who elected to enroll during their employer's one-time Open Enrollment period should be allowed another Open Enrollment period once coverage has been terminated by the Carpenters' Plan. You can contact the Carpenters' Benefit Plans Office for a letter of termination to present to your employer. When enrollment has been established with the employer's health coverage, the Carpenters' Plan will pay as a 'Secondary' carrier.

Verification Form Required:

All dependent spouses eligible for coverage in the Carpenters' Plan must submit a fully completed and signed verification form showing either they are 'Exempt' or they have obtained health coverage through their own employment. All dependent spouse benefits under the Carpenters' Plan will be terminated (or suspended in the case of a new spouse) from the time the form is due until the completed and signed form is received by the Carpenters' Plan. Coverage will only be reinstated the first day of the following month after receipt of the completed and signed verification form. No retroactive coverage will be granted.

Opting Out:

Spouses may elect to 'Opt Out' of coverage in the Carpenters' Plan by checking the appropriate box in Part C on the Verification Form for the Spousal Coverage Program. A dependent spouse who elects to 'Opt Out' of coverage is terminating their coverage in the Carpenters' Plan.