Verification Form for the Policy for Spouses WITHOUT Access to Other Health Coverage Except Medicare
Plumbers & Pipefitters Local Union #25 Health & Welfare Fund

Member Name	Member SSN:	Spouse Name

SPOUSE: Please complete option 1 **OR** option 2 and the information below that best applies to your situation.
BOTH MEMBER & SPOUSE MUST SIGN BELOW.

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Option 1

☐ I do not have or no longer* have group health coverage other than P&PLU25 Health & Welfare.

Note: **Check one box below (1-4) to explain why you do not have coverage**

1) ☐ I am not or no longer employed.
If I am no longer employed, my last day of employment (if within the last year):_____
If applicable, my health coverage termination date is:_____

*A Certificate of Creditable Coverage is required from your insurance carrier.

2) ☐ I am retired Retirement date:_____ Are you on Medicare: Yes_____ No_____

3) ☐ I am self-employed (see guidelines for definition). Name & Type of Business:_____

4) ☐ I am employed, but do not have coverage in my employer's health plan

a) ☐ I will be eligible for coverage after Open Enrollment
Coverage will begin on:_____

b) ☐ I am an employee currently in a "Waiting period."
Coverage will begin on:_____

c) ☐ I am employed 24 hrs or less per week

d) ☐ My employer offers health coverage, but does not contribute 50% or more of the premium cost of employee only coverage

e) ☐ My employer does not offer health coverage

f) ☐ Offered insurance but declined coverage

g) ☐ Other. Explain_____

*** Employer Verification: Must be completed by Employer if Box 4 (a-g) is checked ***

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 Phone #

Employer Representative (please print) Title/Position

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Member/Spouse Signature and Authorization

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 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 | Please Give Best Daytime Phone | Date

Spouse Signature | Please Give Best Daytime Phone | Date

Email Address:_____

Verification Form for the Policy for Spouses WITH Access to Other Health Coverage
Plumbers & Pipefitters Local Union #25 Health & Welfare Fund
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Member Name	Member SSN:	Spouse Name

SPOUSE: Please complete option 1 **OR** option 2 and the information below that best applies to your situation.
BOTH MEMBER & SPOUSE MUST SIGN BELOW.

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Option 2

☐ I have group health coverage other than P&PLU25 Health & Welfare. (Fill in your coverage information below)

Note: **Employer must complete the following information**

Insurance Company Name or Plan Name (or attach copy of both sides of Medical Card):	Insurance Company/Plan Phone#	Coverage Effective Date:

Coverage includes (Check all that apply):						
☐	Medical & Prescription Drug	☐	Employee Only	☐	Family (Please List) _____
☐	Vision	☐	Employee Only	☐	Family (Please List) _____
☐	Dental	☐	Employee Only	☐	Family (Please List) _____

Does the Employers Insurance Co. follow Birthday or Gender Rule:…..	☐	Birthday Rule	☐	Gender Rule
Is this coverage Retiree Coverage?.....	☐	No	☐	Yes
Is this coverage an HRA (Health Reimbursement Account)?.....	☐	No	☐	Yes
Does the Employer provide for 50% or more of the cost of single coverage by any means?.....	☐	No	☐	Yes
Does the Employer provide any type of premium subsidy of the cost of single coverage?.....	☐	No	☐	Yes
What is the Employ**er**'s cost per month/week for single coverage?	☐	Month	☐	Week Amount $ _____
What is the Employ**ee**'s cost per month/week for single coverage?	☐	Month	☐	Week Amount $ _____
Do you have Medicare Coverage?.....	☐	No	☐	Yes

If Yes, ☐ Part A ☐ Part A&B Medicare Effective Date:

*** Employer Verification: Must be completed by Employer ***

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 — Phone #

Employer Representative (please print) — Title/Position

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Member/Spouse Signature and Authorization

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 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 — Please Give Best Daytime Phone — Date

Spouse Signature — Please Give Best Daytime Phone — Date

Email Address:_____