Spousal Coverage Verification Form

MO-KAN SHEET METAL WORKERS WELFARE FUND
P.O. Box 300019 Kansas City, MO 64130-0019
(866) 531-5488 (816) 753-7252 FAX

I. Member Information

_______________________________________ ______/______/______ ________-________-________
Name of Member (Last) (First) (M.I.) Date of Birth Social Security Number

_______________________________________ ______/______/______ ________-________-________
Name of Spouse (Last) (First) (M.I.) Date of Birth Social Security Number

____
Street Address City State Zip Code

____
Telephone # Member's E-mail Address

Member's Employment Status:
□ Active
□ Retired
Do you (member) have Medicare Coverage? □ Yes □ No
If YES, is Medicare due to End Stage Renal Disease? □ Yes □ No
If YES, when did it become effective? _____/_____/_____

Spouse's Employment Status:
□ Active
□ Retired
Does your Spouse have Medicare? □ Yes □ No
If YES, is Medicare due to End Stage Renal Disease? □ Yes □ No
If YES, when did Medicare become effective? ____/_____/_____

II. Marital Status

☐ Widowed: Sign Certification below. Date of Spouse's Death: ______/______/______
☐ Married: Date of Marriage: ______/______/______
☐ Divorced: Date of Divorce: ______/______/______
☐ Legally Separated: Date of Separation: ______/______/______

III. Spousal Employment

Is your spouse employed?

☐ Yes (complete page 2 of form)
☐ No (complete bottom of this form)
☐ Self-employed (complete bottom of form)
☐ I am employed 24 hours or less per week (complete page 2 of form)

IV. Certification of True Statement

I certify that all of the information contained on this form is accurate and complete to the best of my knowledge.

Member's Signature: ____ Date: ____________________

Spouse's Signature: ____ Date: ____________________

V. Other Insurance Coverage Information – To Be Completed By Spouse

Spouse Name: ____

Employer Name: ____

Phone Number (____) ________________________

Employer's Address: ____

City: ____________________________ State: _____________________ Zip Code: __________

Hire Date: __________________________ Current Position: ______________________________

☐ **My employer does not offer health insurance coverage at this time. *(Skip to the last page to sign and date)***

☐ **I am not electing to enroll in my employer's sponsored health care plan. *(Skip to the last page to sign and date)***

Spouse's Coverage Includes (check all that apply):

☐ Medical & Prescription Drug

Coverage Type:

□ Employee Only □ Employee + Spouse □ Employee + Child (ren) □ Family

Name of Medical Insurance Carrier: ____

Address of Medical Insurance: ____

City: __________________________ State: __________________ Zip Code: ____________

Phone Number of Medical Insurance: (____) ____________

Policy Number (as it appears on the card): ___________________ Group Number: ____________________

Effective Date on Plan: ________________________

Is this Medical Plan a:

High Deductible Health Plan (HDHP)? □ Yes □ No

Health Savings Account (H.S.A.) Plan? □ Yes □ No

Rx Carrier:

If Prescription Carrier is different than above, Name of Rx Carrier: ______________________________

Phone Number of Rx Carrier: (____) ____________________

☐ Dental

Coverage Type:

□ Employee Only □ Employee + Spouse □ Employee + Child (ren) □ Family

Name of Medical Insurance Carrier: ______________________________

Address of Medical Insurance: ______________________________

City: ____________________ State: ______________ Zip Code: __________

Phone Number of Medical Insurance: (____) __________

Policy Number (as it appears on the card): ____________ Group Number: ______________

Effective Date on Plan: ______________

☐ Vision

Coverage Type:

□ Employee Only □ Employee + Spouse □ Employee + Child (ren) □ Family

Name of Medical Insurance Carrier: ______________________________

Address of Medical Insurance: ______________________________

City: ____________________ State: ______________ Zip Code: __________

Phone Number of Medical Insurance: (____) __________

Policy Number (as it appears on the card): ____________ Group Number: ______________

Effective Date on Plan: ______________

If provided by a Union, please list the name and local number: ______________________________

I hereby certify that all the information in this section is accurate and complete to the best of my knowledge. I hereby authorize my employer to release information regarding my employer's health insurance plan and my eligibility for coverage under that plan to the Fund. I understand this authorization remains in effect as long as I am eligible for benefits under the Fund. I understand the purpose and scope of this authorization is to allow the Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.
I also understand that if my employment status or the availability for insurance coverage through my employment changes, it is my responsibility to notify the Fund office immediately.

Spouse's Signature: ______________________________ **Date:** ____________________