410 Chickamauga Ave
Suite 301
Rossville, GA 30741
WSF_Support@nifmcp.com

Phone (706) 841-7000
Toll Free (877) 937-9602
Fax: (706) 841-7020
www.nifmcp.com

2024 SPOUSE EMPLOYMENT DATA FORM

YOU AND YOUR SPOUSE MUST SIGN WHERE INDICATED BELOW
RETURN FORM TO THE ADDRESS ABOVE

EMPLOYEE INFORMATION

1. Full Name:______________________________ **SSN:** ______________

2. Address: ____

3. Email Address:______________________________ **Cell Phone No:** ______________

SPOUSE INFORMATION

1. Full Name:______________________________ **SSN:** ______________

2. Spouse's Employment Status: ❍ Not Employed ❍ Employed Full-time ❍ Employed Part-time ❍ Self-employed ❍ Retired

3. Name of spouse's employer: ______________________________ **Date of Hire:** ______________

4. Contact person and telephone number at spouse's employer : ______________________________

5. Does spouse's employer offer a healthcare plan for its employees? ❍ Full-time ❍ Part-time ❍ No

6. Is spouse eligible to enroll in employer's healthcare plan? ❍ Yes ❍ No **7. Is your spouse enrolled?** ❍ Yes ❍ No

WORKING SPOUSE RULE: This Plan requires that your spouse enroll in his or her employer's health coverage. If your spouse fails to enroll, this Plan will reduce its payment of benefits to 20% of covered charges for your spouse. Failure to complete and return this form to the Benefit Office will result in termination of coverage for your spouse. If your spouse's employer does not offer coverage or offers coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead confirming lack of coverage. There is a hardship exemption to the working spouse rule for spouses earning: a) less than $29,000 per year; or b) between $29,000 and $44,000 per year if the coverage costs your spouse more than $200 per month. If you wish to claim the hardship exemption, you must answer #8a and #8b and submit a letter from your employer confirming your salary and monthly health coverage premium. Refer to your Summary Plan Description for a full explanation.

8a. Annual Salary (for current calendar year): ______________ **8b. Monthly Insurance Premium:** ______________

9. If not currently enrolled, when is your spouse's next enrollment opportunity? ______________ **Coverage Effective Date?** ______________

ANSWER THE FOLLOWING QUESTIONS IF YOUR SPOUSE IS ENROLLED IN HIS OR HER EMPLOYER'S HEALTHCARE PLAN.

10. Has the Insurance Plan changed since the last enrollment period? ❍ Yes ❍ No **If so, what is the effective date?**______________

11. What was the termination date of prior coverage? (You MUST include a copy of the Letter of Creditable Coverage): ______________

12. Provide the name of the insurance company/plan (Include a photocopy of both sides of your medical ID card): ______________

____

13. Plan information – Group No.:______________________ Individual ID No.: ______________

❍ Single coverage ❍ Family coverage ❍ Other (explain) ______________

SIGNATURES

EMPLOYEE'S SIGNATURE

I affirm that the information given on this form is true and correct to the best of my ability. I understand that failure to provide truthful an/or complete information may result in the termination of my and my dependents' coverage with the Plan.

______________________________ ______________
Employee's Signature **Date**

SPOUSE'S SIGNATURE (AUTHORIZATION TO RELEASE INFORMATION)

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility and costs for coverage under that plan to the NECA/IBEW Family Medical Care Plan (FMCP). This authorization shall remain in effect as long as I am eligible for benefits under the FMCP. I affirm that the information provided on this form is true and correct to the best of my ability.

______________________________ ______________
Spouse's Signature **Date**