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NECA / IBEW
FMCP
Family Medical Care Plan

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2025 SPOUSE EMPLOYMENT DATA FORM

YOU AND YOUR SPOUSE MUST SIGN WHERE INDICATED BELOW
RETURN THE FORM TO THE MAILING ADDRESS, EMAIL ADDRESS, OR FAX NUMBER LISTED 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 their employer's health coverage. If your spouse fails to enroll, this Plan may reduce its payment of medical and pharmacy benefits to 20% of covered charges 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 spouse's employer confirming their 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 THEIR 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 and/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**