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SPOUSE EMPLOYMENT DATA FORM

➡ **YOU AND YOUR SPOUSE MUST SIGN WHERE INDICATED BELOW.**

1. EMPLOYEE INFORMATION.

1. Full name _____
2. SSN or Indiv. ID#_____
3. Address _____
4. Marital status: ❑ single ❑ married/date _____ ❑ divorced ❑ other (explain)

2. SPOUSE INFORMATION.

1. Full name of spouse _____
2. Spouse's SSN _____
3. Spouse's employment status: ❑ not employed ❑ employed full-time ❑ employed part-time ❑ self-employed ❑ retired
4. Name and address of spouse's employer _____
5. Contact person and telephone number at spouse's employer _____
6. Date of hire _____ 7. Does spouse's employer offer a healthcare plan for its employees? ❑ yes ❑ no
8. Is spouse eligible to enroll in employer's healthcare plan? ❑ yes ❑ no 9. Is spouse enrolled? ❑ yes ❑ no

WORKING SPOUSE RULE: This Plan requires that your spouse enroll in his or her employer's health plan. If your spouse fails to enroll, this Plan will reduce its benefits to 20% of covered charges. If you fail to complete this form his or her coverage will be terminated. If your spouse's employer offers health coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead that explains the reason for his or her ineligibility.

There is a hardship exemption to the working spouse rule for spouses earning: a) less than $20,000 per year; or b) between $20,000 and $30,000 per year if the coverage costs your spouse more than $150 per month. Answer No. 10a and 10b below ONLY if you want to claim the hardship exemption. In addition, attach a letter attesting to wages and cost of coverage from the employer on company letterhead.

10a. Annual salary (for current calendar year) $ _____10b. Amount employee pays per month $ _____

11. If not enrolled, when is spouse's next enrollment opportunity? _____ When would coverage begin?_____

Answer the following questions if spouse is enrolled in his or her employer's healthcare plan.

12. Give name and address of insurance company/plan (or attach a photocopy of both sides of medical ID card) _____ _____

_____

13. Plan information: Group No. _____ Indiv. ID No. _____

all that apply: ____ ❑ major medical/PPO ❑ high deductible HRA ❑ HMO ❑ other (explain)
❑ single coverage ❑ family coverage ❑ other (explain) _____
❑ dental ❑ vision

3. SIGNATURES.

EMPLOYEE'S SIGNATURE

I affirm that the information given on this form is true and correct to the best of my ability.

➡ _____ _____
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 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

4. SUBMIT TO FUND OFFICE. Mail completed form to the FMCP at 410 Chickamauga Ave Suite 301, Rossville, GA 30741.