410 Chickamauga Ave
Suite 301
Rossville, GA 30741

Family Medical Care Plan

Phone (706) 841-7000
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SPOUSE EMPLOYMENT DATA FORM 2022

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

1. EMPLOYEE INFORMATION.

1. Full name _____ SSN or Card ID# _____
2. Address _____
3. Email Address: _____ Cell Phone No. _____

2. SPOUSE INFORMATION.

1. Full name of spouse _____ Spouse's 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 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.

- ***If your spouse's employer does not offer Medical Insurance you must provide a letter on company letterhead confirming that the Medical Benefits are not offered.***

There is a hardship exemption to the working spouse rule for spouses earning: a) less than $23,000 per year; or b) between $23,000 and $35,000 per year if the coverage costs your spouse more than $200 per month.

Answer No. 8a and 8b below ONLY if you want to claim the hardship exemption. A letter attesting to wages and cost of coverage MUST BE PROVIDED from the employer on company letterhead. (W2s and Check Stubs are NOT acceptable)

8a. Annual salary (for current calendar year) _____ 8b. Monthly Insurance Premium _____

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

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 12. 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) _____

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. Or fax to (706) 841-7020