Spousal Coverage Verification Form

Roofers Local No. 20 Health and Welfare Fund

6321 Blue Ridge Blvd., Suite 101, Raytown, MO 64133 ♦ (816) 313-9427

Do you wish to participate in the Working Spouse Incentive Program? ☐ Yes ☐ No*
If no, then you do not need to complete this form.

I. PARTICIPANT INFORMATION

Name of Participant (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 # ______ Participant's E-mail Address ______

Employment Status: ☐ Retired ☐ Active

Do you have Medicare Coverage? ☐ Yes ☐ No
If YES, is it due to End Stage Renal Disease? ☐ Yes ☐ No
If YES, when did it become effective? ____/____/____

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

☐ Single (no need to complete form)
☐ Widowed (no need to complete form)
☐ Married

III. 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.

Participant's Signature: ______________________ Date: ______________

Spouse's Signature: ______________________ Date: ______________

IV. SPOUSAL EMPLOYMENT

Is your spouse employed?

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

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: ______________________

Name of Other Insurance: ______________________________

Address of Other Insurance: ______________________________

City: ______________________ State: ______________ Zip Code: ______________

Phone Number of Other Insurance: ______________ Policy Number (as it appears on the card): ______________

Group Number: ______________________ Effective Date: ______________________

Coverage Includes (check all that apply):

☐ Medical and Prescription Drug	☐ Employee Only	☐ Family
☐ Vision	☐ Employee Only	☐ Family
☐ Dental	☐ Employee Only	☐ Family

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

I hereby certify that all of 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 that this authorization remains in effect as long as I am eligible for benefits under the Fund. I understand that 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.

Participant's Signature: ______________________________ **Date:** ______________