THE NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND

4208 W PARTRIDGE WAY, UNIT 3

PEORIA, IL 61615

SPOUSAL INSURANCE COVERAGE INFORMATION

PART 1. MEMBER INFORMATION (To be completed by the Member and spouse)

Member's Name: _____ SS# _____

Spouse's Name: _____ SS# _____

Is Spouse Employed? Yes ☐ Member and spouse to sign below and continue to Part II

NO ☐ Member and spouse to sign below and return form to Fund Office

Member's Certification: I certify that the above information is correct and that I understand my responsibility to notify you of any changes. I understand that if my spouse is eligible to participat in his or her employer-sponsored group health insurance plan, then that plan will be considered primary even if my spouse does NOT enroll in the plan.

Member's Signature **Date**

Spouse's Authorization to Realease Information: I hereby authorize my employer to release the information requested below to the North Central Illinois Laborers' Health & Welfare Fund or it's claims administration, for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

Spouse's Signature **Date**

PART II. INFORMATION ON SPOUSE'S PLAN (To be completed by the spouse's employer.)

Your Employee's Name: _____

Last, First, Middle

	Medical	
	YES	NO
Is employee eligible for your employee-sponsored group health insurance plan?	☐	☐
Is this employee currently enrolled in your plan?	☐	☐
Do you, the employer, pay at elast 75% of the single coverage premium?	☐	☐
Does your plan enroll the employee in another plan and offer them a reduced medical coverage (for example, a "wrap-around" plan) based only on the fact that they are a participant/dependent in this Fund?	☐	☐

If employee is NOT enrolled in your plan, when will the employee be eligible to enroll in the plan?

_____ Comments: _____

Month/Day/Year

Employer Name: _____ Insurance Carrier Name: _____

Address _____ Address _____

_____ _____

_____ _____

Telephone Policy # _____

Group # _____

If eligible employee is NOT enrolled in your plan (at least 75% of premium paid by the employer), please send Summary Plan Document.

Completed by: _____

Signature Date

_____

Print Name and Title

You MUST enroll at your next open enrollment if your employer pays at least 75% of the single coverage premium.