



Spousal Coverage Verification Form

MO-KAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019 – Kansas City, MO 64130-0019 – (816) 531-0334 or (866) 531-5488

I. MEMBER INFORMATION

Name of Member (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 # Member's E-mail Address

Employment Status: Retired Active Do you have Medicare Coverage? Yes No Does your Spouse have Medicare? Yes No If YES, is it due to End Stage Renal Disease? Yes No If YES, when did it become effective? / /

II. Marital Status

- Widowed: Sign Certification below. Date of Spouse's Death: / /
Married: Date of Marriage: / /
Divorced: Date of Divorce: / /
Legally Separated: Date of Separation: / /

IV. Spousal Employment

- Is your spouse employed?
Yes (complete page 2 of form)
No (complete bottom of this form)
Self-employed (complete bottom of form)
I am employed 24 hours or less per week (complete page 2 of form)

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:

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: _____

- My employer does not offer health insurance coverage at this time. (Skip to the bottom to sign and date)
- I am not electing to enroll in my employer's sponsored health care plan. (Skip to the bottom to sign and date)

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):

<input type="checkbox"/> Medical & Prescription Drug.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Vision.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Dental.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family

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

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

Spouse's Signature: _____ Date: _____