

**UFCW Local 1776 & Participating Employers Health and Welfare Fund
DECLARATION OF SPOUSE HEALTH COVERAGE**

Participant name: _____ **Social Security Number:** _____

Spouse name: _____ **Social Security Number:** _____

- My spouse is (check one):
_____ not currently employed
_____ employed full-time
_____ employed part-time (number of hours regularly scheduled each week _____)
_____ self-employed

- My spouse is employed by:
Employer's Name: _____
Employer's Address: _____
Employer's Phone: _____

Spouse Employer's Health Coverage

- My spouse's employer does not offer group health coverage for which he/she is eligible
 My spouse is currently covered by his/her employer's groups health insurance

Name of health plan or insurance company: _____
Identification/Policy Number: _____ Effective date of coverage: _____

Coverage is for: _____ Employee only _____ Employee & Spouse _____ Family

Coverage includes (check all that apply):

_____ Medical _____ Dental _____ Vision _____ Prescription Drugs

- My spouse is eligible for group health coverage through his/her employer but has declined
 My spouse's employer requires a contribution to participate If so, how much? \$ _____
 My spouse's employer offers a financial incentive to decline coverage.
If so, how much? \$ _____
 Other (explain) _____

I declare that the information is true and correct to the best of my knowledge, information and belief. I understand that the UFCW Local 1776 & Participating Employers Health & Welfare Fund reserves the right to suspend or terminate my group health coverage if it concludes that I have provided false or misleading information in this Declaration. I understand that my spouse's group health plan from his/her employer is his/her primary insurance plan. The Fund will only consider claims for payment that have first been submitted to my spouse's employer's plan. If my spouse should change employment, or his/her eligibility for health coverage should change, I am required to notify the Fund office and complete an updated Declaration of Spouse Health Coverage.

Date

Participant Signature