NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND

4208 West Partridge Way, Unit #3
Peoria, IL 61615

SPOUSE INSURANCE COVERAGE INFORMATION

PART I. MEMBER INFORMATION (To be completed by member and spouse.)

Member's Name: ______________________________ SS#: ____________________

Spouse's Name: ______________________________ SS# ____________________

Is Spouse Employed?: Yes ☐ Member and spouse to sign below and continue on Part II.
No ☐ Member to sign below and return form.

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 participate 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.

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Member's Signature Date

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

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Spouse's Signature Date

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

Your Employee's name: ______________________________________
Last, First, Middle

	MEDICAL YES	MEDICAL NO
Is employee eligible for your employer-sponsored group health insurance plan?	☐	☐
Is this employee currently enrolled in your plan?	☐	☐
Do you, the employer, pay at least 75% of the single coverage premium?	☐	☐
Does your plan enroll the employee in another plan and offer them 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 currently 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 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.