Spouse Declaration of Health Coverage

Dear Member,

The purpose of this form is to obtain coordination of benefits information so we may determine if our Plan is the primary or secondary payor for your spouse and dependants.

Our Plan requires working spouses enroll in their employer’s health plan if their premium is $40 per month or less. Our Plan also requires working spouses enroll in their employer’s dental plan if they pay less than 50% of the premium.

If the cost of your spouse’s health and/or dental coverage exceeds the criteria above, or if coverage is not available to your spouse, the Fund Office must have a letter from the employer stating that fact.

Failure to make a complete disclosure of other group insurance will result in delay of payment of claims. Any overpayment by our office must be reimbursed.

I trust this is of assistance to you and clarifies the position of the Fund on coordination of benefits. Should you have any questions regarding this matter please feel free to contact our office at 515-243-3246 or in Iowa 1-866-894-4500.

Sincerely,

Jama Barbour
Fund Administrator
PLUMBERS & STEAMFITTERS LOCAL UNION NO. 33
HEALTH AND WELFARE FUND
DECLARATION OF SPOUSE HEALTH COVERAGE
(To avoid any interruption in the processing of your claims, please complete the form and return to the Fund Office)

Member Name: ______________________________ Member’s S.S. No.: ______________

Spouse Name: ______________________________ Spouse’s S.S. No.: ______________

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

2) My spouse is employed by:
   Employer’s Name: ______________________________
   Address: ______________________________
   ______________________________
   H.R. Contact Person: ______________________________
   Phone Number: ______________________________

3) Information about my Spouse’s Insurance Options through his/her Employer (check one):
   ___ My spouse is eligible for group health coverage through his/her employer, but has declined coverage because
   Please note: If you check this option, you are required to submit a copy of your spouse’s health insurance options offered by his/her employer.
   ___ My spouse is currently covered by his/her employer’s health insurance.

   Name of health plan or insurance company: ______________________________
   Identification/Policy Number: ______________________________ Effective Date of Coverage __________________
   Coverage includes (check all that apply):
   ___ Medical  ___ Dental  ___ Rx Drugs  ___ Vision

   Coverage is for:
   ___ Employee only  ___ Employee and Spouse  ___ Family

(Use this area to provide additional information and or explanations) ______________________________

I declare that the information is true and correct to the best of my knowledge, information and belief. I understand that
the Fund reserves the right to suspend or terminate my health coverage if it concludes that I have provided false or
misleading information in this Declaration. I understand that if my spouse’s employer offered group health insurance,
my spouse must enroll in his/her employer’s plan unless it meets criteria stated on reverse side. I understand that if my
spouse does not enroll, he/she is ineligible to be covered as a dependent in the Fund’s Plan. Finally, 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 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 ______________________________

Spouse Signature ______________________________

Fund Office use only.

Employer info on file __________
Other info needed __________

Follow up date and info requested ______________________________

Processing of your claims may be delayed until this information is provided. Therefore, please return this completed
form to the Fund Office promptly.