PLUMBERS AND STEAMFITTERS
LOCAL UNION 33

Jama Barbour
Fund Office Administrator
jbarbour@ualocal33.org

Health and Welfare Fund
2501 Bell Avenue
Des Moines, Iowa 50321-1118

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.