



**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,

Jamie Smith  
Fund Office Supervisor

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: \_\_\_\_\_ Last 4 of Member's SSN: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Last 4 of Spouse's SSN: \_\_\_\_\_

**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#: \_\_\_\_\_

**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

Are you offered any type of FSA (Flexible Spending Account), HRA (Health Reimbursement Account) or HSA (Health Savings Account) by your employer?

Yes  No

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

**Under penalties of perjury, I/We jointly declare that the information contained in this document is true and correct to the best of my/our knowledge, information, and belief.** I/We understand that if my spouse's employer offers group health insurance, my spouse must enroll in his/her employer's plan unless it meets criteria stated on reverse side. I/We also understand that we are required to submit documentation from his/her employer showing that the criteria is met. I/We understand that if my spouse does not enroll, he/she is ineligible to be covered as a dependent on Plumbers and Steamfitters Local 33 Health Plan. Finally, I/We 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 \_\_\_\_\_

<b>Fund Office use only.</b>
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.