UFCW UNIONS AND EMPLOYERS HEALTH AND WELFARE PLAN OF CENTRAL OHIO
4150 E. Main St. Columbus, Ohio 43213 Phone: 614-237-7618 Fax: 614-338-0226

Affidavit of Health Care Coverage for Spouse/Common Law Spouse

Name of Member: _____ Name of Spouse/Common Law Spouse: _____

Important: please ensure this form is FULLY COMPLETED.
Your response, or lack of response, will impact your spouse's healthcare coverage.

SECTION I: Spouse/Common Law Spouse Employment Information

Is your spouse/common law spouse currently employed?

□ Yes (continue to Section II)

□ Self-employed (continue to Section III)

□ Not employed / Retired (continue to Section III)

If your spouse/common law spouse is eligible for medical care or treatment provided by a health maintenance type of organization ("HMO") and does not utilize the services, facilities or providers covered by such an organization, your spouse will not be eligible for benefits from this Plan. This rule applies regardless of whether you are otherwise eligible for dependent coverage under the Plan.

If your spouse/common law spouse is enrolled in and covered under the Plan and your spouse/common law spouse is also eligible for health coverage through his or her employer (other than the same employer as you), *an additional monthly employee contribution to the Plan will be required if your spouse/common law spouse does not enroll in his or her employer's plan*. *This additional employee contribution will remain in effect until your spouse/common law spouse enrolls in the available employer plan.*

SECTION II: Employer Certification of Spouse/Common Law Spouse Health Benefit Coverage

NOTE: this section must be completed in full by your spouse/common law spouse's employer

1. Is the spouse/ common law spouse named above eligible for health benefits through your company? **YES NO**

2. If so, is the spouse/ common law spouse enrolled in health care coverage? **YES NO**

3. Is the Healthcare insurance ACA compliant? **YES NO**

4. If enrolled, Insurance Carrier Name:_____ **Policy No.**_____ **Effective Date** _____

Type of Coverage: Individual or Employee & Children or Employee & Spouse or Family

Name of employer: _____

Address of employer: _____

Name of Representative (Printed): _____ Phone: ( ) _____

Signature of Representative: _____

Title: _____ Date: _____

Section III: Acknowledgement – must be signed by above-named UFCW Unions' and Employers' Health & Welfare Plan of Central Ohio Member

I certify and warrant to UFCW Unions' and Employers' Health & Welfare Plan of Central Ohio that all information on this form is true, correct and current. I understand as a member that falsification of information on this Affidavit may lead to disciplinary action, up to and including termination of employment.

_____ _____

Member Signature *(required)* Date