ROOFERS LOCAL # 195
HEALTH, ACCIDENT & PENSION FUNDS

6200 State Route 31 • Cicero, New York 13039 • Phone: (315) 699-1388 • Fax: (315) 699-1390

SPOUSE INSURANCE INFORMATION REQUEST FORM

If your spouse is employed, part or full-time, (s)he must have the following form completed and signed by his/her employer. If your spouse is not employed, please write **"Not Employed"** under the Spouse Insurance Information section below, sign the form at the bottom, and return to the Fund Office.

Member Information

Member Name:_____ Birthdate:_____
SS#: _____ Street Address:_____
City:_____ State:_____Zip Code:_____
Phone ( ) _____Cell Phone: ( )_____Email:_____

Spouse Information

Spouse Name: _____ Birthdate:_____
SS#: _____ Street Address:_____
City: _____ State:_____Zip Code:_____
Phone ( )_____Cell Phone: ( )_____Email: _____

Spouse Employer Information – *EMPLOYER MUST COMPLETE THIS SECTION*

Spouse's Employer Name:_____Employer Phone: ( )_____
Employer Street Address:_____City: _____State:_____Zip:_____
Supervisor's Name: _____Phone: ( )_____
Employer Fax: ( )_____

Does your company offer Medical Insurance Benefits to their employees? Yes_____No_____
Is this employee eligible for these benefits through your company? Yes_____No_____
Is this Employee currently enrolled in your Medical Insurance Plan? Yes_____No_____
If No, why?_____
What is the date of your next open enrollment or enrollment period?_____
Does your company offer an "Opt-out" incentive program? Yes_____No_____
Is your Medical Insurance Plan employer contributed: Yes_____No_____
If yes, what %?_____
What is the cost per month to the employee for ***Self-Only Medical*** Insurance? $_____/month
What is the Gross pay of the employee per month? $_____/month
What type of Medical coverage is offered to your employee? _____Family _____Self

Employer Signature:_____Title:_____
Employer Printed Name:_____Date:_____

The Fund Office reserves the right to request updated employment information and/or proof of health insurance availability at any time. Any person who knowingly, and with intent to defraud the Roofers Local #195 Health & Accident Fund, files a false statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Per the Summary Plan Description Booklet when a participant's spouse has health insurance or expense benefits available to him/her under his/her employer's plan, there will be no coverage under this benefit Plan, unless such spouse enrolls in his/her employer's plan. We will then coordinate benefits with the spouse's employer plan as a secondary payer.
An exception will be considered if the cost for his/her enrollment is substantial **(more than 10% of her/his gross pay)**. Note that if he/she is enrolled in his/her employer's plan, coordination with that plan will take place, in the event of a claim with his/her plan paying first. **If the spouse fails to enroll in his/her plan**, when there is no exception granted based on cost, the Plan will coordinate benefits as if the Spouse were enrolled in their employers plan. The Fund Office has the right to require submission of the spouse's employer plan documents to coordinate these benefits. ***Failure to submit required documentation will result in denial of claims.***