Central Laborers' Pension, Welfare & Annuity Funds

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http://www.central-laborers.com

CENTRAL LABORERS' WELFARE FUND
SPOUSE INSURANCE COVERAGE INFORMATION

INFORMATION ON SPOUSE'S PLAN (To be completed by spouse's employer)

Your Employee's Name: _____

Is employee eligible for your employer-sponsored group health insurance plan? ☐**Yes** ☐**No**

Is the employee currently enrolled in your insurance plan(s)? ☐**Yes** ☐**No**
If yes, please note the coverage: ☐ **Health** ☐ **Prescription** ☐ **Dental** ☐ **Vision**

Does the employee work full time or part time?_____ **Full Time Hire Date** _____

If employee is NOT currently enrolled in your health plan, when will the employee be eligible to enroll in the plan?
With effective date: _____ **Month/Day/Year** _____ **Month/Day/Year**

Employer Name: _____ **Employer Address:**_____
Employer Telephone: _____

Health Insurance Carrier Name: _____ **Phone Number:** _____
Group and Policy Number: _____

Prescription Drug Carrier Name: _____ **Phone Number:** _____
Group and Policy Number: _____

Dental Insurance Carrier Name: _____ **Phone Number:** _____
Group and Policy Number: _____

Vision Insurance Carrier Name: _____ **Phone Number:** _____
Group and Policy Number: _____

Completed By: _____
Signature **Date**

_____
Please print Name and Title

Spouse's Authorization to Release Information: I hereby authorize my employer to release the information requested above to Central Laborers' Welfare Fund for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

Spouse Signature **Date**

Member's Certification: I certify that the above information is correct and that I understand my responsibility to notify you of any changes. I understand that if my spouse is eligible to participate in his or her employer-sponsored group health insurance plan, then that plan will be considered primary even if my spouse does not enroll in the plan.

Member Signature **ID#** **Date**