# ROCKY MOUNTAIN UFCW UNIONS
# & EMPLOYERS HEALTH BENEFIT PLAN

ADMINISTRATION OFFICE
P. O. Box 447 Arvada, CO 80001-0447 (303) 430-9334

## SPOUSAL COVERAGE VERIFICATION

Name of Participant: _____ Name of Spouse: _____
[Print Name] [Print Name]
Participant Social Security Number: _____

**Important: please ensure this form is fully completed.**
**Your response, or lack of response, may impact your spouse's health care coverage.**

**SECTION I: Spouse Employment Information**

Is your spouse currently employed?

☐Not employed (sign below, skip Section II)

☐Self-employed (sign below, skip Section II)

☐Yes (sign below, continue to Section II)

☐Yes, my spouse is employed and was offered other medical coverage by his/her employer but is not enrolled in such coverage. I understand and agree that I will pay an additional co-premium in the amount of $23.08 per week as a deduction from my paycheck. This $23.08 is in addition to the $17.00 co-premium for Employee and Spouse coverage; or the $26.00 co-premium for Family (Employee, Spouse, and Dependent Child(ren)) coverage. (sign below, do not continue to Section II)

I certify under penalty of perjury, that the foregoing is true, correct and current.

_____ _____
Participant Signature *(required)* Date

**SECTION II: Employer Certification of Spouse's Health Benefit Coverage**

*NOTE: this section must be completed in full by your spouse's employer*

**1.** Is the spouse named above eligible for employee health benefits through your company? ☐Yes ☐No

**2.** If Yes, is the Spouse currently enrolled in healthcare coverage? ☐Yes ☐No

**3.** If No, did the spouse waive or fail to enroll in coverage? ☐Yes ☐No

**4.** If No, when will the spouse be eligible to enroll in health benefits through your company _____ (the date the spouse will be eligible for coverage)?

Name of employer: _____

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

Signature of Representative: _____

Title: _____ Date: _____