Welfare Fund of Local No. One, I.A.T.S.E.

Spousal Coverage Confirmation

Please complete this form **ONLY** if you have elected medical coverage for your spouse

Each participant who has elected medical coverage for his or her spouse must complete the following information. This initiative is intended to ensure that each spouse covered under the Plan is accurately listed and eligible for coverage. Each participant must certify that the person listed below is his or her spouse and that they are not separated or divorced. Please make sure that you have provided all of the information requested below. If you fail to fill out and return this Spousal Coverage Confirmation form by December 1, 2014, your spouse's coverage will be suspended effective January 1, 2015.

Participant Name: _____ Last four digits of SSN: ___ ___ ___ ___

Spouse Name: _____ Last four digits of SSN: ___ ___ ___ ___

I hereby certify that my spouse and I are currently married and not separated. ☐ Yes ☐ No

Participant Acknowledgement of Responsibility:

I have read the above information regarding the spouse requirement for health insurance coverage under the Plan. I have also read the Plan eligibility requirements in the SPD. I acknowledge that the information on this form is accurate to the best of my knowledge. I understand that if any false statement is made or information withheld, the Trustees of the Welfare Fund of Local No. One, I.A.T.S.E. will hold me legally responsible for all costs associated with extending coverage to my spouse after our legal separation or divorce became final. This could include the full premium expense for such coverage and the full cost of all claims expense incurred after the legal separation or divorce. I also understand that any false statement made or information withheld could result in the immediate termination of my health insurance coverage and the health insurance coverage of my other dependents.

Participant Signature: _____

E-mail Address: _____

Phone Number: _____

United States Code, Title 18 Section 1035(a): Whoever, in any matter involving a health care benefit program, knowingly and willfully—(1) falsifies, conceals or covers up by any trick, scheme, or device a material fact; or (2) makes any materially false writing or document knowing the same to contain any materially false, fictitious or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.