TEAMSTERS LOCAL 639 – EMPLOYERS

HEALTH & PENSION TRUST FUNDS

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TEAMSTERS LOCAL 639—EMPLOYERS HEALTH TRUST FUND

SPOUSAL HEALTH COVERAGE INFORMATION FORM

THIS FORM MUST BE COMPLETED BY ALL ACTIVE, MARRIED OR RECENTLY DIVORCED OR WIDOWED PARTICIPANTS AND RETURNED TO THE FUND OFFICE BEFORE YOUR SPOUSE WILL BE ELIGIBLE FOR BENEFITS.

The Board of Trustees of the Teamsters Local 639–Employers Health Trust Fund has adopted a spousal surcharge requirement for the 639 Health Plan ("Plan"). This requirement is described more fully in the Summary Plan Description ("SPD") effective January 1, 2011. To satisfy this requirement, both you and your spouse must complete and sign this Form, enclose the information requested on the next few pages, and hand deliver or mail the Form and the enclosures to the Fund Office (at the address set out above). Failure to return a completed and signed Form and supporting documentation will cause your spouse's coverage to be suspended and/or terminated.

PART 1 PARTICIPANT AND SPOUSE INFORMATION

Name of Participant
Participant's Social Security No.
Participant's Address
Name of Spouse
Spouse's Social Security No.
Name, Address and Telephone No. of Spouse's Employer

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.

PART 2 SPOUSAL HEALTH COVERAGE INFORMATION

YOU MUST CHECK ONE OF THE BLOCKS BELOW. CONTACT THE FUND OFFICE AT 202-636-8181 IF YOU HAVE QUESTIONS

Box 1	**I Am No Longer Married:**
☐	I do not need spousal coverage from the Plan because I am not married. If I have previously reported having a spouse to the Plan, attached is a copy of my divorce decree proving I am now single.

Box 2	**My Spouse Is Not Employed:**
☐	My spouse is not employed and therefore does not have health coverage through her/his employer. As proof, I have enclosed our most recent and signed Form 1040 and W-2s which confirm that my spouse is not employed. If the tax form indicates employment, but your spouse is no longer employed, please provide a termination letter from your spouse's employer. Subject to the Plan's verification, I understand that the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 3	**My Spouse Is Employed. My Spouse's Employer Does Not Offer Health Coverage:**
☐	My spouse is employed, but, my spouse's employer does not offer any health coverage or she/he is not eligible for any coverage that is offered. As proof, I have enclosed a letter from my spouse's employer confirming that my spouse's employer does not offer any employer sponsored health coverage. You may contact my spouse's employer to verify this information. If spouse is self-employed please have spouse provide a notarized statement indicating no health coverage. Subject to the Plan's verification, I understand that the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 4	**My Spouse Is Employed. My Spouse's Employer Does Offer Health Coverage, But That Coverage Is Not "Adequate," As Explained Below:**
☐	My spouse is employed and my spouse's employer does offer health coverage. However, her/his employer's plan does not meet the Plan's definition of "adequate alternative coverage" (see the SPD, page 13) because all of the individual coverage options would require my spouse to pay a monthly contribution of more than $330. As proof, I have enclosed either: (a) a copy of my spouse's open enrollment materials from her/his most recent open enrollment; or, (b) a signed statement from my spouse's employer confirming that all individual coverage options under the employer's plan require monthly contributions of more than $330. You may contact my spouse's employer to verify this information. Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

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Box 5 ☐

My Spouse Is Employed. My Spouse's Employer Does Offer Health Coverage. But That Coverage Is Not "Adequate," As Explained Below:

My spouse is employed and my spouse's employer does offer health coverage. However, her/his employer's plan does not meet the Plan's definition of "adequate alternate coverage" (see the SPD page 13) because all of the individual or family coverage options have a High Deductible Health Plan (HDHP) as defined by the IRS. The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2014.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,250	$2,500
Maximum annual deductible and other out-of-pocket expenses*	$6,350	$12,700

* The above amounts only apply to deductibles and expenses for in-network services if the plan uses a network of providers.

Self-only HDHP coverage is an HDHP covering only an eligible individual. Family HDHP coverage is an HDHP covering an eligible individual and at least one other individual (whether or not that individual is an eligible individual).

As proof, I have enclosed either: (a) a copy of my spouse's open enrollment materials from her/his most recent open enrollment; or, (b) a signed statement from my spouse's employer confirming that all individual coverage options under the employer's plan is a high deductible health plan. You may contact my spouse's employer to verify this information.

Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 6 ☐

My Spouse Is Employed. My Spouse's Employer Offers "Adequate" Health Coverage. But My Spouse Can't Enroll In That Coverage Right Now:

My spouse is employed and has "adequate alternate coverage" (defined in the SPD page 13) available through her/his employer. However, my spouse has specifically asked her/his employer when my spouse may enroll in the employer's plan and the employer has informed my spouse that she/he will not be able to enroll in that coverage until:

_____

Insert date at which spouse can first become eligible for alternate coverage through her/his employer

As proof, I have enclosed: (a) my spouse's open enrollment materials from her/his most recent open enrollment confirming the above open enrollment dates; or, (b) a letter from my spouse's employer confirming that my spouse will not be eligible to enroll in her/his employer sponsored plan until the date specified above.

Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with primary coverage and **will not require us to pay the spousal surcharge** until the date set out above. **AFTER THAT DATE, I UNDERSTAND THAT MY SPOUSE WILL HAVE TO ENROLL IN HER/HIS EMPLOYER'S PLAN OR START PAYING THE SPOUSAL SURCHARGE TO THE PLAN.**

Box 7 ☐

My Spouse Is Employed. My Spouse Has Obtained Health Coverage From Her/His Employer:

My spouse is employed and is currently enrolled in coverage offered by his/her employer.

Therefore, I understand that the Plan will provide my spouse with "secondary" coverage only (my spouse's employer sponsored coverage will be "primary") and **will not require us to pay the spousal surcharge**. [If you have not already done so, please complete the enclosed Coordination of Benefits Form.]

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Box 8	**My Spouse Is Employed. My Spouse Will Not Obtain Health Coverage From Her/His Employer. We Will Pay The Plan's Spousal Surcharge:**
☐	My spouse is employed and has "adequate alternate coverage" (defined in the SPD page 11) available through her/his employer, but my spouse has decided not to enroll in her/his employer's plan. My spouse wants to stay covered by the Plan and **we will pay the monthly spousal surcharge**, currently set at $388/month. My spouse and I understand that the spousal surcharge payment must be made in advance of the month for which spousal coverage is requested. **IF PAYMENT IS NOT RECEIVED ON A TIMELY BASIS, COVERAGE WILL BE TERMINATED AND MY SPOUSE WILL NOT BE PERMITTED TO RE-ENROLL IN SPOUSAL COVERAGE FROM THE PLAN FOR A PERIOD OF 12 MONTHS.**

Box 9	**My Spouse Is Employed. My Spouse Will Not Obtain Health Coverage From Her/His Employer. We Will Not Pay The Plan's Spousal Surcharge.**
☐	My spouse is employed and does have "adequate alternate coverage" (defined in the SPD page 13) available through her/his employer, but my spouse has decided not to enroll in her/his employer plan. Furthermore, we will not enroll in or pay the Plan's monthly spousal surcharge. My spouse and I understand that she/he will not be covered by the Plan and that she/he will not be able to re-enroll in spousal coverage under the Plan for a 12-month period.

PART 3 PARTICIPANT AND SPOUSE CERTIFICATION

I/we certify, under penalty of perjury, that the information provided on this Form and submitted herewith is complete and accurate. I/we understand that, in addition to possible criminal penalties, the Plan may suspend my coverage and my family's coverage for a period of one year and require us to repay all benefits paid by the Plan on the spouse's behalf, if I/we make false or incorrect statements about my spouse's employment status or the health coverage that is or is not available through my spouse's employer.

Participant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

RETURN THIS FORM, COMPLETED AND SIGNED, AND WITH THE REQUIRED ACCOMPANYING MATERIALS, TO THE FUND OFFICE IN ORDER FOR YOUR SPOUSE TO BE ELIGIBLE FOR BENEFITS. THE ADDRESS OF THE FUND OFFICE IS STATED AT THE TOP OF THE FIRST PAGE OF THIS FORM.

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.