Iron Workers St. Louis District Council Trust Funds

P.O. Box 1096 • Maryland Heights, MO 63043 • Phone 314.656.1091 • Toll Free 877.597.8704 • Fax 314.739.1105

Mandatory Annual Working Spouse Coverage Verification Form

Member Name	SSN	Spouse Name

BOTH MEMBER AND SPOUSE MUST SIGN BELOW!

SPOUSE: Please Complete the Information Requested Below.

SECTION I: Please check the correct box regarding your employment status:

☐ I am **NOT** employed. No further information is needed; please sign and return.

☐ I am self-employed. Name and Type of Business: _____
No further information is needed; please sign and return.

☐ I am employed - Section II must be completed.

SECTION II: Please check the appropriate box below. Your HR Department must complete the Employer Verification section.

☐ I am employed but my employer does not offer health coverage.

☐ I am employed, but do not have coverage in my employer's health plan for the reason indicated below:

_____

☐ I am employed and have coverage through my employer. A copy of my insurance card is enclosed with this form.

*****EMPLOYER VERIFICATION: Must be completed by Employer if Section II is completed*****

Employer Name: _____

I hereby certify the spouse named on this form is an employee of the Employer above and the information supplied by the spouse is accurate and complete to the best of my knowledge.

Employer Representative Signature _____ Date _____

Employer Representative (Please Print) _____

Position _____ Phone _____

MEMBER/SPOUSE SIGNATURE AND AUTHORIZATION: BOTH MUST SIGN

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the Iron Workers St. Louis District Council Health & Welfare Fund (Fund) to verify the spouse's employment status as needed. We understand that if any incorrect or misleading information results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from us or by withholding from our future benefits.
Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the Fund.

Member Signature _____ Date _____

Spouse Signature _____ Date _____

01/2024