NORTHWESTERN OHIO PLUMBERS AND PIPEFITTERS BENEFIT PLANS

7570 Caple Blvd., Suite B / Northwood, Ohio, 43619 / Telephone (419) 662 1388 / Fax (419) 662 1733

<<LAST NAME>>, <<FIRST NAME>> <<MI>>
<<ADDRESS 1>>
<<ADDRESS 2>>
<<CITY>>, <<STATE>> <<ZIP>>

February 2017

Dear Surviving Spouse:

As you are aware, the NW Ohio Plumbers and Pipefitters Health and Welfare Plan allows for you to remain covered under the medical plan until such time that other comparable coverage becomes available to you or you remarry. At this time, the Plan is undergoing an audit. Part of this audit includes a review of eligibility for coverage for surviving spouses, so it is necessary to obtain information from each surviving spouse for certain information that can be used to verify eligibility for coverage.

Please complete the enclosed Surviving Spouse Questionnaire and return to the Fund Office within two weeks from the receipt of this letter. A self-addressed envelope is enclosed for your convenience. Failure to respond may result in your claims being delayed for payment, as we will have to undertake additional efforts to verify your eligibility for coverage. In addition, intentionally providing false or materially misleading information can be grounds for retroactive termination of your coverage.

Thanking you in advance for your cooperation and assistance.

If you have any questions, please call the Fund Office at 419 662 1388.

Sincerely,
NW Ohio Plumbers and Pipefitters Fund Office

SURVIVING SPOUSE QUESTIONNAIRE

Please Print

The following questions pertain to any other health insurance that you or any of your dependents may have or have been offered through employment or through a new spouse, if you have remarried. These questions do not pertain to coverage that is provided by Medicare or the NW Ohio Plumbers and Pipefitters Health and Welfare Plan.

_____ _____ _____

First Name Last Name Social Security Number

Employment Statement

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed

Name of Employer: _____

Employer Street Address: _____

Employer City, State, Zip: _____

Employer Phone: _____

If you answered that you are employed full or part time, was health coverage offered to you through your employer?

Yes No (circle one)

If No: State The Reason: _____

If Yes Coverage Effective Date: _____

If Yes: Name of Insurance Carrier: _____

If you answered that you are employed full or part time, was prescription drug coverage offered to you through your employer?

Yes No (circle one)

If No: State The Reason: _____

If Yes Coverage Effective Date: _____

If Yes: Name of Insurance Carrier: _____

(OVER)

SURVIVING SPOUSE QUESTIONNAIRE

Please Print

If you answered that you are employed full or part time, did you decline to enroll for any of the above coverage?

Yes No

If so, why did you decline? _____

Are you required to make a contribution to maintain the health or prescription coverage offered through your employer?

Yes No (circle one)

Is dependent coverage included?

Yes No (circle one)

Have you remarried? ☐ Yes ☐ No

If no, skip to the bottom of the form, date and sign below

Was medical or prescription coverage offered to you through your spouse's plan/employer?

☐ Yes ☐ No

Did you decline to enroll for coverage through your spouse's plan/employer?

Yes No

If so, why did you decline? _____

Are you required to make a contribution to maintain coverage through your spouse's plan/employer?

Yes No (circle one)

Is dependent coverage included with your spouse's plan/employer?

Yes No (circle one)

Additional Comments: _____

_____

_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my NW Ohio Plumbers and Pipefitters Plan become eligible for any other coverage. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits and recoupments of claims paid.

_____ _____

Signature *Date*

PLACE

STAMP

HERE

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NORTHWESTERN OHIO PLUMBERS AND PIPEFITTERS
BENEFIT PLANS
7570 CAPLE BLVD SUITE B
NORTHWOOD OH 43619

Attn: Stephanie DeWitt –
SS Audit Response