THE NELSON TRUST

FAILURE TO COMPLETE AND RETURN THIS FORM WILL RESULT IN THE TERMINATION OF SPOUSE COVERAGE EFFECTIVE JANUARY 1, 2025

- **Web: www.nelsonbenefits.org**
- **Fax: (**503) 228-0149
- **Mail:** PMB #116, 5331 S Macadam Avenue, Suite 258, Portland OR 97239
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For questions regarding this form, please call (800) 811-8853 or visit us at www.nelsonbenefits.org

EMPLOYEE NAME
1234 MAIN ST
ANYTOWN, US 12345

Dependent: SPOUSE

TO BE COMPLETED BY THE ABOVE-LISTED SPOUSE

☐ **Yes, I am employed. Please have the employer complete the form**

By signing below, I acknowledge that my response to the above question is accurate. If I am employed, I authorize my employer to complete and return to me the section below.

Signature of Spouse:_____ **Date:**_____

TO BE COMPLETED BY THE EMPLOYER OF THE LISTED SPOUSE:

☐ We offer group medical coverage with _____, and this employee is enrolled.
☐ We offer group medical coverage with _____; and this employee was eligible but did not enroll.
☐ We do not offer group medical coverage to our employees
☐ We offer group medical coverage with _____, but this employee is part-time and is not eligible.

If the employee is enrolled in group medical coverage offered, please list the cost per paycheck to enroll for medical in the space below. If more than one medical plan is offered, list the employee cost of the base plan or most prevalent medical plan option.

Employee only $_____ Employee + Spouse $_____ Employee + Child(ren) $_____ Employee + Family $_____

☐ Bi-Monthly	☐ **Bi-Weekly**	☐ **Monthly**

My signature is confirmation that the group benefits plan information I have provided above is true and accurate.

Signature of Employer Representative_____ Date___/___/_____

Print Representative Name_____ Title. _____

Print Employer Name_____ Business Phone (____)_____