SPOUSE SURCHARGE AFFIDAVIT

Due Date: 11/12/2022

Employees may choose to have their spouse covered under the Plan; however, a surcharge will apply for those spouses **who have access** to other employer sponsored coverage but who still wish to enroll under this plan as their Primary insurance or Secondary insurance.

Employees with spouses **who do not have access** to other employer sponsored coverage are exempt from the surcharge, to include employees with spouses working for Conagra.

The surcharge will be deducted from your paycheck if you have a spouse covered under your medical plan. To make a change due to a qualifying life event, you will have 30 days from the date of the qualifying event to make your election.

To be completed by you, the Member of this Plan			
Employee's Name:		**Employee's SSN:**	
Spouse's Name:		**Spouse's SSN:**	
Spouse's Social Security #:			
Is your spouse employed?	□ Yes, Name of Employer:	□No	Employer Phone No.:
Is your spouse self-employed?	□ Yes	□No	

If applicable, date your spouse retired or became unemployed:

If your spouse has coverage available through his/her employer:

- □ My spouse has elected coverage through his/her employer. I elect to pay the Spouse Surcharge Fee of $150 per month. I consent to having this fee collected by my employer via payroll deduction and I understand this Fund will provide secondary coverage.
- □ My spouse has declined coverage through his/her employer. I elect to pay the Spouse Surcharge Fee of $150 per month. I consent to having this fee collected by my employer via payroll deduction and I understand that this Fund will provide primary coverage for my spouse.

If your spouse is not employed or does not have coverage available through his/her employer:

- □ My spouse is unemployed or has no health coverage available through his/her employer. I understand that this Fund will provide primary coverage for my spouse.

Name of Spouses Insurance:	**Effective Date of Insurance:**

CERTIFY: I hereby certify that the information provided is correct. I understand that any misrepresentation in the information I have provided will permit UFCW Local 1529 and Employers Health & Welfare Plan & Trust to terminate the spouse coverage and seek any other legal remedies available including possible prosecution for fraud. I also understand that if my spouse becomes eligible for medical coverage from his or her employer during the plan year, I must notify the Plan Administrator withing 30 days. I understand if my spouse is/was eligible through their employer and I have not been charged the applicable surcharge, I will be responsible for applicable surcharges for the period my spouse is covered under the plan.

Employee's Signature	
Date	